Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, February 13, 2015

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
February 13, 2015

MISSION STATEMENT:

To reduce death and disability resulting from sudden or serious injury and illness in the Commonwealth through planning and development of a comprehensive, coordinated statewide emergency medical services (EMS) system; and provision of other technical assistance and support to enable the EMS community to provide the highest quality emergency medical care possible to those in need.

I. Executive Management, Administration & Finance

a) Action Items before the State EMS Advisory for February 13, 2015

At the time of finishing this report there were no action items reported from any Standing Committees or Work Groups of the Board.

b) Proposed Emergency Medical Services Budget for FY2016 of the2014 – 2016 Biennium

Item 284	Emergency Medical Services (40200)	46,620,756	46,620,756
	Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203)	35,148,150	35,148,150
	State Office of Emergency Medical Services (40204)	7,472,606	7,472,606
	Fund Sources: Special	17,847,721	17,847,721
	Dedicated Special Revenue	24,367,452	24,367,452
	Federal Trust	405,583	405,583

Authority: §§ 32.1-111.1 through 32.1-111.16, 32.1-116.1 through 32.1-116.3, and 46.2-694 A 13, Code of Virginia.

A. Out of this appropriation, $25,000 the first year and $25,000 the second year from special funds shall be provided to the Department of State Police for administration of criminal

history record information for local volunteer fire and rescue squad personnel (pursuant to § 19.2-389 A 11, Code of Virginia).

B. B. Distributions made under § 46.2-694 A 13 b (iii), Code of Virginia, shall be made only to nonprofit emergency medical services organizations.

C. Out of this appropriation, $1,045,375 the first year and $1,045,375 the second year from the Virginia Rescue Squad Assistance Fund and $2,052,723 the first year and $2,052,723 the second year from the special emergency medical services fund shall be provided to the Department of State Police for aviation (med-flight) operations.

D. The State Health Commissioner shall review current funding provided to trauma centers to offset uncompensated care losses, report on feasible long-term financing mechanisms, and examine and identify potential funding sources on the federal, state and local level that may be available to Virginia's trauma centers to support the system's capacity to provide quality trauma services to Virginia citizens. As sources are identified, the commissioner shall work with any federal and state agencies and the Trauma System Oversight and Management Committee to assist in securing additional funding for the trauma system.

E. Notwithstanding any other provision of law or regulation, the Board of Health shall not modify the geographic or designated service areas of designated regional emergency medical services councils in effect on January 1, 2008, or make such modifications a criterion in approving or renewing applications for such designation or receiving and disbursing state funds.

F. Notwithstanding any other provision of law or regulation, funds from the $0.25 of the $4.25 for Life fee shall be provided for the payment of the initial basic level emergency medical services certification examination provided by the National Registry of Emergency Medical Technicians (NREMT). The Board of Health shall determine an allocation methodology upon recommendation by the State EMS Advisory Board to ensure that funds are available for the payment of initial NREMT testing and distributed to those individuals seeking certification as an Emergency Medical Services provider in the Commonwealth of Virginia.

G. Out of this appropriation, up to $400,000 the first year and up to $400,000 the second year from the Virginia Rescue Squad Assistance Fund shall be used for grants to emergency medical services organizations to purchase 12-lead electrocardiograph monitors.

H. Out of this appropriation, $90,000 the first year and $90,000 the second year from the Virginia Rescue Squad Assistance Fund shall be provided for national background checks on persons applying to serve as a licensed provider in a licensed emergency medical services agency. The Office of Emergency Medical Services may transfer funding to the Office of State Police for national background checks as necessary.

Poison Control Centers – Item 291 Payments to Human Services Organizations (49204)

Paragraph Q - Out of this appropriation, $1,000,000 the first year and $1,000,000 the second year from the general fund shall be used to support three poison control centers. The State Health Commissioner shall review existing poison control services and determine how best to provide and enhance use of these services as a resource for patients with mental health disorders and for health care providers treating patients with poison-related suicide attempts, substance abuse, and adverse medication events. The Commissioner shall allocate the general fund amounts between the three centers. The general fund amounts shall be based on the proportion of Virginia's population served by each center.

§3-1.01 INTERFUND TRANSFERS

Paragraph T - The State Comptroller shall transfer quarterly, one-half of the revenue received pursuant to § 18.2-270.01, of the Code of Virginia, and consistent with the provisions of § 3-6.03 of this act, to the general fund in an amount not to exceed $9,055,000 the first year, and $9,055,000 the second year from the Trauma Center Fund contained in the Department of Health's Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203).

Paragraph Y - On or before June 30 each year, the State Comptroller shall transfer $10,518,587 the first year and $10,518,587 the second year to the general fund from the $2.00 increase in the annual vehicle registration fee from the special emergency medical services fund contained in the Department of Health's Emergency Medical Services Program (40200).

Paragraph - ZZ.1. On or before June 30 of each year, the State Comptroller shall transfer amounts estimated at $32,195,521 the first year and $1,475,000 the second year from the agencies and fund sources listed below to the general fund of the state treasury.

	Fund	FY 2015	FY 2016
Department of Health (601)			
Capture balance from the Emergency Medical Services Fund	0213	$4,000,000	$1,000,000
Capture Trauma Center fund nongeneral fund balances	0902	$500,000	$0

§3-3.03 INTEREST EARNINGS

Paragraph A – Notwithstanding any other provisions of law, the State Comptroller shall not allocate interest earnings to the following agencies in the first year of the biennium. The estimated amount of interest earnings that shall remain in the general fund as a result of this provision is $11,389,754 the first year and $11,389,754 the second year:

Agency	Agency Code	Fund Name	Fund Detail
Department of Health	601	Trauma Center Fund	0902
Department of Health	601	Virginia Rescue Squad Assistance Fund	0910

§3-6.02 ANNUAL VEHICLE REGISTRATION FEE ($4.25 FOR LIFE)

Notwithstanding §46.2-694 paragraph 13 of the Code of Virginia, the additional fee that shall be charged and collected at the time of registration of each pickup or panel truck and each motor vehicle shall be $6.25.

c) Legislation Introduced in the 2015 Virginia General Assembly Directly Impacting EMS or Bills of Interest to EMS.

Legislation tracked by the Office of EMS is included in a Grid in **Appendix A** of this report. The status of these bills are as of Friday, January 30, 2015. There are six (6) bills that the Office of EMS has been assigned as lead agency to track, testify and make recommendations to the Commissioner of Health. These six bills follow:

1) HB1584 - Fire services and emergency medical services. Revises terminology related to fire services and emergency medical services and reorganizes provisions governing fire services and emergency medical services. The bill also contains technical amendments.

2) SB938 - Fire services and emergency medical services. Revises terminology related to fire services and emergency medical services and reorganizes provisions governing fire services and emergency medical services. The bill also contains technical amendments.

Note: HB1584 and SB938 are companion bills

3) HB1660 - Recognition of EMS Personnel Licensure Interstate Compact. Creates the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact to (i) protect the public through verification of competency and ensuring of accountability for patient-care-related activities of licensed emergency medical services (EMS) personnel,(ii) facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority, and (iii) authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state.

4) SB877 - Recognition of EMS Personnel Licensure Interstate Compact. Creates the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact to (i) protect the public through verification of competency and ensuring of accountability for patient-care-related activities of licensed emergency medical services (EMS) personnel, (ii) facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority, and (iii) authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state.

Note: HB1660 and SB877 are companion bills

5) SB837 - Emergency medical services personnel; background checks; process. Creates an alternative method for national criminal history background checks for emergency medical services personnel, allowing local governments that have procedures in place for the collection of fingerprints and personal descriptive information and the forwarding of such fingerprints and information directly to the Federal Bureau of Investigation to do so instead of forwarding fingerprints and information through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the national criminal history background checks.

6) SB997 - Emergency medical services personnel; background checks; process. Creates an alternative method for criminal history background checks for emergency medical services personnel, allowing local governments that have procedures in place for the collection of fingerprints and personal descriptive information and the forwarding of such fingerprints and information directly to the Department of State Police or the Federal Bureau of Investigation to do so instead of forwarding fingerprints and information through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the national criminal history background checks.

d) EMS Voluntary Event Notification Tool (E.V.E.N.T.)

E.V.E.N.T. is a program of the Center for Leadership, Innovation, and Research in EMS (CLIR) with sponsorship provided by the North Central EMS Institute (NCEMSI), the National EMS Management Association (NEMSMA), the Paramedic Chiefs of Canada (PCC), the National Association of Emergency Medical Technicians (NAEMT) and the National Association of State EMS Officials (NASEMSO).

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected is used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool (Patient Safety Event, Near Miss Event, Violence Event, Line of Duty Death). The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

Appendix B contains the following reports:

Patient Safety Events reported to E.V.E.N.T. in the third quarter of 2014 (July through September 2014).

Provider Violence Events reported to E.V.E.N.T. for the third quarter of 2014 (July through September 2014).

Near Miss reported from calendar year 2013. There were not enough incidents to report any meaningful data for any quarter during calendar year 2014.

Visit www.emseventreport.com for more information about E.V.E.N.T.

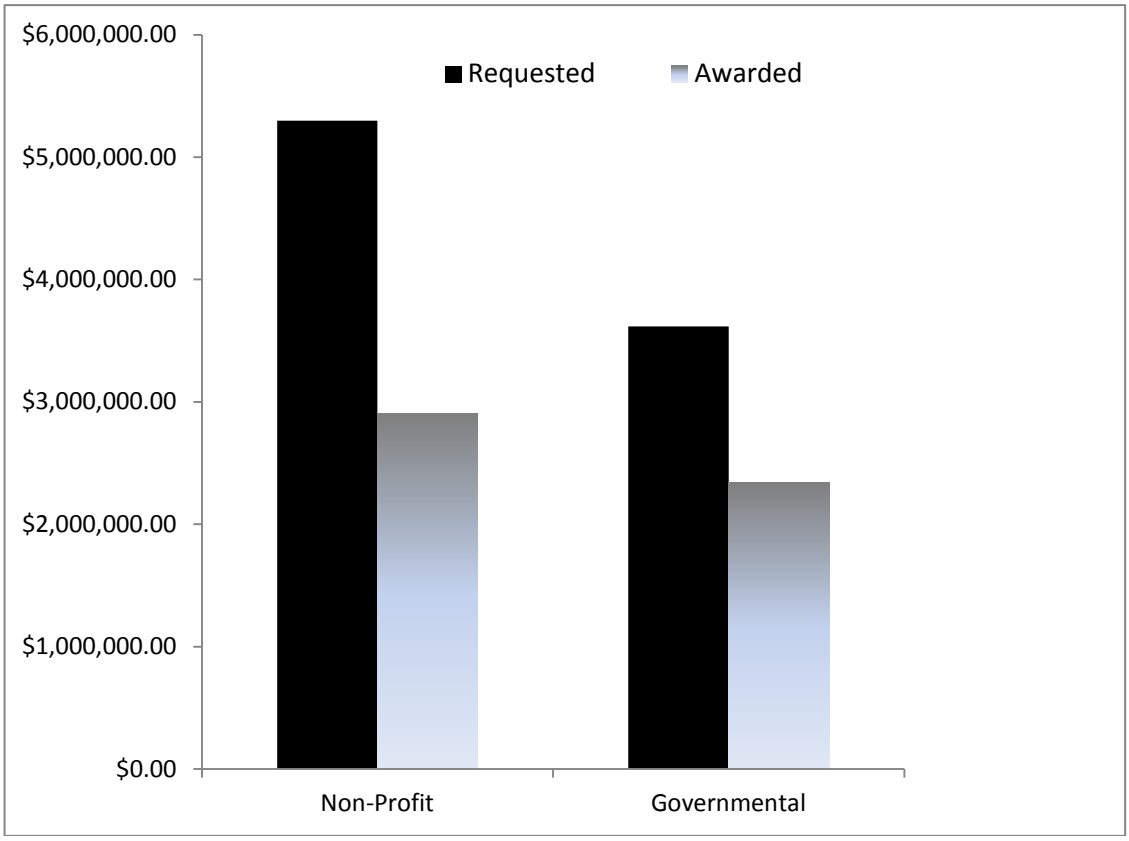
e) Financial Assistance for Emergency Medical Services (FAEMS) Grant Program, known as the Rescue Squad Assistance Fund (RSAF)

The RSAF grant deadline for the December 2014 grant cycle was September 15, 2014, OEMS received 125 grant applications requesting $8,914,211.00 in funding. OEMS funded 106 agencies in the amount of $5,241,511.77.

Funding was awarded in the following agency categories:

- 64 Non-Profit Agencies awarded $2,902,351.00
- 42 Government Agencies awarded $2,339,160.00

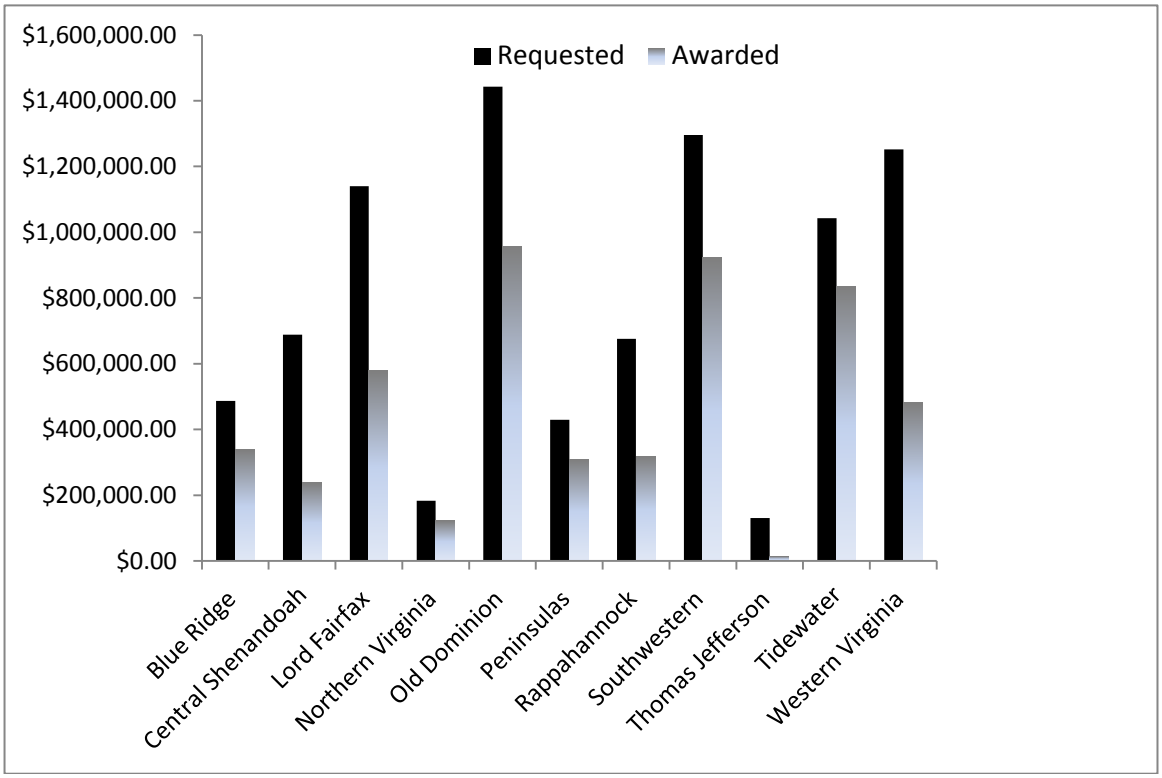
Figure 1: Requested vs Amount Awarded by Agency Category



The following EMS regional areas were awarded funding in the following amounts:

- Blue Ridge EMS Council – 8 agencies awarded $338,379.00
- Central Shenandoah EMS Council – 5 agencies awarded $238,322.00
- Lord Fairfax EMS Council – 9 agencies awarded $578,585.00
- Northern Virginia EMS Council - 4 agencies awarded $123,266.00
- Old Dominion EMS Alliance – 18 agencies awarded $957,880.00
- Peninsulas EMS Council – 6 agencies awarded $308,472.00
- Rappahannock EMS Council – 7 agencies awarded $319,211.00
- Southwestern Virginia EMS Council – 16 agencies awarded $922,253.00
- Thomas Jefferson EMS Council – 2 agencies awarded $14,822.00
- Tidewater EMS Council – 12 agencies awarded $836,100.00
- Western Virginia EMS Council – 16 agencies awarded $480,995.00

Figure 2: Requested vs Amount Awarded by EMS Regions



Note: Three non-affiliated agencies were awarded funding in the amount of $123,227.00, this information is not represented in Figure 2.

RSAF Grants Awarded by item categories:

- 12 –Lead – $1,249,873.00
  - Includes all 12-Lead Defibrillators.

- Audio Visual and Computers - $ 119,61200
  - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.

- Communications - $ 107,120.00
  - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.

- Emergency Operations - $ 117,057.00
  - Includes items such as Mass Casualty Incident (MCI) All Terrain Vehicle (ATV), extrication equipment and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.

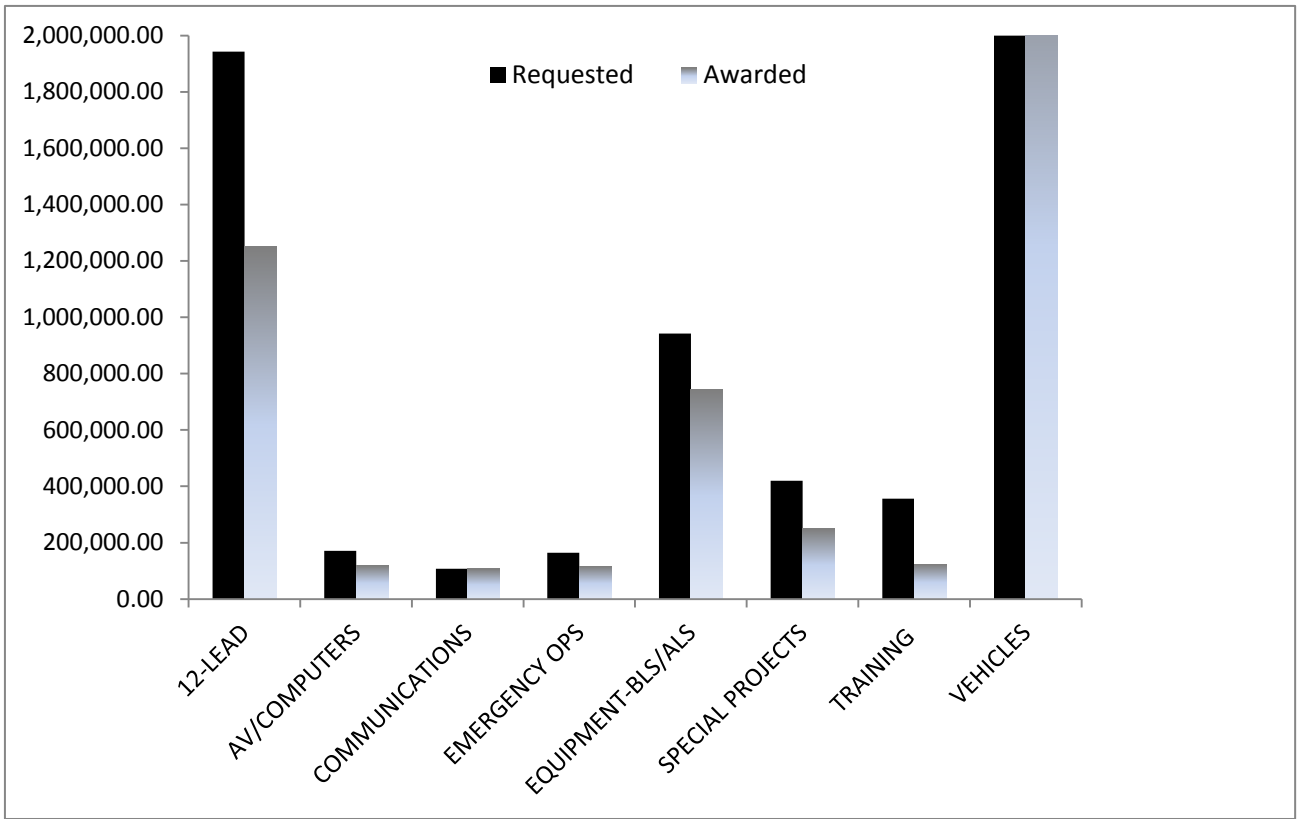
- Equipment - Basic and Advanced Life Support Equipment - $ 742,756.00
  - Includes any medical care equipment for sustaining life, airway management, and supplies, not including 12-Lead Defibrillators.

- Special Projects - $ 249,168.00
  - Includes projects such as Recruitment and Retention, Special Events Material, Emergency Medical Dispatch (EMD), Virginia Pre-Hospital Information Bridge (VPHIB) projects and other innovative programs.

- Training - $ 123,931.00
  - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.

- Vehicles – $2,531,994.00
  - Includes ambulances, 1st Response/Quick Response Vehicles (QRV) and rechassis/remount of ambulances.

Figure 3: Requested vs Amount Awarded by Item



Note: The Vehicles category had a requested amount of $4,811,208.00 with an award amount of $2,531,994.00. The figure represents categories up to $2,000,000.00 to give a clearer picture of the data.

The Spring 2015 grant cycle will begin on February 1, 2015 with a deadline of March 16, 2015; grants will be awarded July 1, 2015.

i. Rescue Squad Assistance Fund Emergency Grants

Duffield Volunteer Fire & Rescue was awarded 1 Type I Dodge Ambulance at 80/20 (state/agency) funding level for $144,101.60 on December 17, 2014. The agency was awarded an ambulance due to major mechanical issues, including transmission and motor failure. The agency is replacing two ambulances for the new ambulance that was awarded. This agency did not have the funding to repair the unit and the lack of use was detrimental to patient care.

New Garden Rescue Squad was awarded 1 Type III Chevrolet Ambulance at 100/0 (state/agency) funding level for $135,000.00 on December 18, 2014. This was awarded to replace an ambulance that had total mechanical failure. The agency was unable to fund a replacement ambulance and the lack of use was detrimental to patient care.

ii. EMS – Grant Information Funding Tool (E-GIFT)

The OEMS Grants Unit and VDH Office of Information Management (OIM) has implemented a web-based grant program to replace the Consolidated Grant Application Program (CGAP) for RSAF. E-GIFT was required for the 12/14 grant cycle. The program has several phases, all which will be completed by Spring 2015:

- Phase I – Grant Application – implemented and required for the 12/14 RSAF grant cycle.
- Phase II – Grant Review – implemented and required for the 12/14 RSAF grant review.
- Phase III – Meeting Program – implemented and required for the December 4-5, 2014 RSAF Grants Award meeting.
- Phase IV – Payments– being developed and will be completed by February 2015.

EMS on the National Scene

II. EMS On the National Scene

National Association of State EMS Officials (NASEMSO)

Note: The Virginia Office of EMS is an active participant in the NASEMSO and has leadership roles on the Board of Directors and in each NASEMSO Council. The National Association of State EMS Officials is the lead national organization for EMS, a respected voice for national EMS policy with comprehensive concern and commitment for the development of effective, integrated, community-based, universal and consistent EMS systems. Its members are the leaders of their state and territory EMS systems.

a) 2015 NASEMSO Board of Directors Announced

During its recent Annual Meeting in Cleveland OH, NASEMSO members elected new officers and Board members for 2015.

- President— Paul Patrick (UT)
- President-Elect— Keith Wages (GA)
- Secretary— Kyle Thornton (NM)
- Treasurer—Gary Brown (VA)
- Immediate Past President-- Jim DeTienne (MT)

Council chairs include:

- Education and Professional Standards- Joseph Ferrell (IA)
- Trauma Managers-Sherri Wren (NE)
- Data Managers- Paul Sharpe (VA)
- Medical Directors- Dr. Peter Taillac (UT)
- Pediatric Emergency Care- Katherine Hert (AL)

Regional representatives to the Board of Directors include Chris Bell (East), Alisa Williams (South Central), Joseph House (North Central), and Andy Gienapp (West). Congratulations and best wishes are extended to all!!

b) NASEMSO Releases National Model EMS Clinical Guidelines

Following the conclusion of a two-year project initiated by the National Association of State EMS Officials (NASEMSO) Medical Directors Council, the **National Model EMS Clinical Guidelines** have now been completed and are available to the public. The project was developed for the purpose of helping state EMS systems ensure a more standardized approach to the

practice of prehospital patient care and to encompass evidence-based guidelines as they are developed. The guidelines are not intended to be mandatory or to determine local scope of practice. Rather, the goal is to provide a resource to prehospital clinical practice, maximize patient care, safety and outcomes. The prehospital guidelines may be used as presented or adapted for use on a state, regional or local level to enhance patient care and benchmark performance of EMS practice. They are intended to be a core set of guidelines, at least initially, with the goal of adding more guidelines in the future. The project was funded by the National Highway Traffic Safety Administration, Office of EMS and the Health Resources Services Administration, EMS for Children Program. The guidelines may be downloaded at: https://www.nasemso.org/Projects/ModelEMSClinicalGuidelines/index.asp

c) NASEMSO - New Initiative on EMS Performance Measures Announced

NASEMSO has entered into a cooperative agreement with the National Highway Traffic Safety Administration (NHTSA) to develop a comprehensive set of EMS performance measures. The two-year project, funded by NHTSA, will engage a wide range of EMS stakeholders to develop performance measures that are relevant to EMS agencies, regulators, and patients. The measures will be based on the latest National EMS Information System (NEMSIS) version data and will allow local and state EMS agencies to use their own data meaningfully. The project will facilitate an inclusive and open development process, with participation from dozens of EMS and healthcare experts and organizations and multiple opportunities for input and public comment. OEMS will share more information as the project develops.

d) NASEMSO Partners with NOSORH in First Rural EMS Leadership Conference

NOSORH's JCREC (Joint Committee on Rural Emergency Care) in association with the National Association of State EMS Officials is planning the first ever meeting for rural EMS leaders and advocates. Plan to attend and support EMS leaders in your state to attend the National Rural EMS Leadership Conference on May 5-6, 2015 in Cheyenne, Wyoming. Topics include: Rural and Frontier EMS Agenda for the Future, Important Role of EMS with CAH, Community Paramedicine, Ambulance Service Sustainability, Legislative Update and more. For more information go to: http://nosorh.org/national-rural-ems-leadership-conference/.

e) NASEMSO Announces Recent Advocacy Efforts

The National Association of State EMS Officials (NASEMSO) is pleased to provide information related to resolutions approved by the membership at its 2014 Annual Meeting that serve to endorse highway safety initiatives and commemorate entities and individuals who have long-served EMS.

- *Towards Zero Deaths: National Strategy on Highway Safety* - The TZD National Strategy is intended to provide a roadmap for the future by identifying key safety focus areas to ensure the greatest progress and to unite efforts of highway safety advocates nationwide.

- *Ambulance Equipment and Crash Testing Standards and Related Safe Transport Recommendations for Children in Ground Ambulances* - NASEMSO resolved to urge federal and organizational partners to support the development of evidence-based standards upon which EMS can make determinations of safe transport practices of children and equipment in ground ambulances.

- *Commemorating Anniversaries and Years of Service to EMS* - NASEMSO recognized 30 year anniversaries of both the EMS for Children Program (EMSC) and the National Association of EMS Physicians (NAEMSP) and commended Liz Sibley on her retirement as the executive director for CECBEMS.

The full text of each resolution is available at:
https://www.nasemso.org/Advocacy/PositionsResolutions/Resolutions.asp

NASEMSO Member Katrina Altenhofen explains the background of "Recommendations for Children in Ground Ambulances" in a recent article featured at EMS World. You can read the full article at: http://www.emsworld.com/article/12006854/pediatric-ambulance-restraint-recommendations

f) NASEMSO Joins Public Safety Partners on Feedback to FCC

The National Association of State Emergency Medical Services Officials (NASEMSO) has joined the International Association of Chiefs of Police (IACP), the International Association of Fire Chiefs (IAFC), and the National Sheriffs' Association (NSA) in filing a letter addressing the Federal Communications Commission's (FCC) proposal to update its wireless indoor location accuracy rules. The organizations commended the FCC for its focus on improving the location information being provided to first responders from wireless devices during 9-1-1 calls. The coalition articulated concerns regarding an alternate timeline to the FCC's proposal suggested by the wireless carriers. In its letter to the FCC, the group expresses support for using performance-based metrics for providing dispatchable location to PSAPs. For more information go to: http://www.nasemso.org/Advocacy/Supported/index.asp

g) NASEMSO Data Managers Offer New Resource on Selecting ePCR Software

NASEMSO's Data Managers Council has just released a resource guide, *"Deciding on ePCR Software: A Guide for EMS Agencies"*, now available on the NASEMSO website at: https://www.nasemso.org/Councils/DataManagers/documents/NASEMSO-Deciding-on-ePCR-Software-19Nov2014.pdf. Developed with input from state data managers, the purpose of the guide is to help EMS agencies make educated decisions when choosing an electronic patient care reporting (ePCR) vendor.

h) NASEMSO Expresses Gratitude for Tireless Efforts to Improve 9-1-1

Laurie Flaherty is an extraordinary emergency nurse and long time advocate for EMS. During the past 10 years, she has led the National 911 Program, a small but important initiative created to give 911 a home within the federal government. The aim of the program, which is housed in

the National Highway Safety Traffic Administration (NHTSA), is to strengthen the country's 911 systems by providing a single point of coordination among the states, technology providers, public safety officials, 911 professionals and other groups. In her role, Flaherty works with public and private partners to ensure that the 6,000 911 call centers nationwide have the resources and capabilities they need to do their jobs seamlessly and to provide optimal services to the public. In a recent article in the Washington Post, the Partnership for Public Service helps highlight Laurie's efforts to raise the bar for 9-1-1 communications. NASEMSO members expressed their gratitude to Laurie on behalf of the 956,058 credentialed EMS professionals and 19,437 credentialed EMS agencies that also serve our Nation each and every day! For more information read the WP article *"Bringing the 911 emergency call service into the digital age"* Go to:
http://www.washingtonpost.com/politics/federal_government/bringing-the-911-emergency-call-service-into-the-digital-age/2014/12/02/e98d830c-7a34-11e4-84d4-7c896b90abdc_story.html

i) FCC Publishes Final Rule on 9-1-1 Reliability

The Federal Communications Commission (FCC) has published a final rule requiring 911 service providers to report major disruptions to emergency networks. The phone companies that service emergency networks will be required to report outages to 911 operators within 30 minutes of discovering the problem. In addition, they will also be required to notify 911 operators as well as leave contact information for emergency officials to reach them and follow up with questions. Except in cases where information is shared with the Department of Homeland Security, the reports will be kept confidential. The new rules go into effect immediately. For more information go to: https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-26117.pdf

j) National Institute for Occupational Safety and Health (NIOSH) Releases Updated Emergency Preparedness Web Page

NIOSH would like to introduce its new Emergency Preparedness and Response Directory web page. The web page offers improved access to NIOSH topics and publications pertaining to responder safety and health, natural disasters and hazards, and NIOSH disaster response efforts, as well as links to related NIOSH programs. For more information go to:
http://www.cdc.gov/niosh/emres/?s_cid=3ni7d2eml09102014

k) Resources for Optimal Care of the Injured Patient 2014 Now Available

The American College of Surgeons Committee on Trauma (ACS-COT) has made the final version (v1.1) of the 2014 Resources for Optimal Care of the Injured Patient document ("Orange Book") available for download. The ACS-COT has created a resource repository, which is referred to in several places throughout Resources for Optimal Care of the Injured Patient 2014. The content related to the criteria is complete. Additional edits to the content are not envisioned until a formal process is developed for ongoing revision of the document. Verification applicants with any visits scheduled on or after July 1, 2015, will be required to meet the criteria contained in the Resources for Optimal Care of the Injured Patient 2014. For more information go to:
https://www.facs.org/quality-programs/trauma/vrc/resources

l) New Motor Vehicle PICCS Can Enhance System Planning Efforts by States

A "Vital Signs" bulletin recently released by the U.S. Centers for Disease Control and Prevention (CDC) highlights the terrible public health burden and economic cost of injuries from motor vehicle crashes – a leading cause of injury in the U.S. generally and consistently the leading cause of U.S. work-related fatalities. More than 2.5 million Americans went to hospital emergency departments and nearly 200,000 were then hospitalized because of motor vehicle crash injuries in 2012, CDC reports. These injuries translated to:

- $18 billion in lifetime medical costs.
- $3,300 in cost for each emergency department visit, and $57,000 in cost for each hospitalization over a person's lifetime.
- An estimated $33 billion in costs for work lost over lifetime.

Proven strategies for preventing motor vehicle crashes and related injuries include the use of car seats, booster seats, and seat belts; interventions to reduce drinking and driving; and improvements in teen driver safety. More information, including recommendations targeted to employers, can be found in the CDC "Vital Signs" bulletin at www.cdc.gov/vitalsigns. In conjunction with the report, CDC also released a new interactive calculator, the Motor Vehicle PICCS (Prioritizing Interventions and Cost Calculator for States). This tool is designed to calculate the expected number of injuries prevented and lives saved at the state level and the costs of implementation, while taking into account available resources. The Motor Vehicle PICCS (pronounced "picks") is available online at: www.cdc.gov/motorvehiclesafety/calculator.

m) Free Online Naloxone Training Program Now Available

Givenaloxone.org has officially launched a free online training program in overdose prevention, recognition and response, funded by the National Institutes of Health and developed with the expertise of emergency physicians, EMS providers and harm-reduction specialists. The training is free and can be completed in about 40 minutes. Self-paced and interactive, it caters to individual learning needs. Those who successfully pass an online test after completing it receive a certificate of completion they can give to their organization. The website also offers separate training for laypeople who wish to learn how to use naloxone and find out where they can obtain a personal prescription. The training may be taken anonymously. EMS may wish to pass on the link to their community members and especially family and friends of patients at risk of overdose.

n) JEMS Provides Active Shooter/TECC Supplement

High-profile and high-fatality active shooter events have put substantial pressure on EMS and other public safety agencies to respond and mitigate threats rapidly, quickly treating injured responders and victims as close to their point of injury as possible. JEMS special editorial supplement presents not just the results and recommendations of the Hartford Consensus, but also the latest data and techniques on how to care for yourself, your co-workers and victims of

violent and fast moving incidents. For more information go to:
http://www.jems.com/special/when-time-matters-most

o) "Outbreaks" Report Rates States in Ability to Respond to Severe Infectious Disease

A report recently released by Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF) finds that the Ebola outbreak exposes serious underlying gaps in the nation's ability to manage severe infectious disease threats. Half of states and Washington, D.C. scored five or lower out of 10 key indicators related to preventing, detecting, diagnosing and responding to outbreaks. Maryland, Massachusetts, Tennessee, Vermont and Virginia tied for the top score – achieving eight out of 10 indicators. The indicators are developed in consultation with leading public health experts based on data from publicly available sources or information provided by public officials. For the state-by-state scoring, states received one point for achieving an indicator or zero points if they did not achieve the indicator. Zero is the lowest possible overall score, 10 is the highest. The data for the indicators are from publicly available sources or were provided from public officials. The indicators are developed in consultation with leading public health experts based on data from publicly available sources or information provided by public officials.

- **8 out of 10:** Maryland, Massachusetts, Tennessee Vermont and Virginia
- **7 out of 10:** California, Delaware, Nebraska, New Hampshire, North Dakota, Pennsylvania and Wisconsin
- **6 out of 10:** Colorado, Connecticut, Florida, Hawaii, Illinois, Iowa, Minnesota, New York, North Carolina, Rhode Island, South Carolina, South Dakota and Texas
- **5 out of 10:** Alabama, D.C., Georgia, Indiana, Michigan, New Mexico, Oklahoma, Oregon, Utah and West Virginia
- **4 out of 10:** Alaska, Arizona, Maine, Mississippi, Missouri, Montana, Nevada and Washington
- **3 out of 10:** Idaho, Kansas, Kentucky, Louisiana, New Jersey, Ohio and Wyoming
- **2 out of 10:** Arkansas

p) DHS Offers Revised National Emergency Communications Plan

The Department of Homeland Security (DHS) released the first updated National Emergency Communications Plan (NECP) since the original in 2008. The NECP is the Nation's over-arching strategic plan for enhancing emergency communications capabilities and interoperability nationwide. The updated NECP addresses the increasingly complex communications landscape that the public safety community uses to keep America safe and secure. The plan provides a roadmap for improving emergency communications for traditional emergency responder disciplines such as law enforcement, fire, and emergency medical services, while recognizing the importance of engaging non-traditional disciplines including public health, public works and transportation agencies. The 2014 NECP focuses on three priorities over the next several years:

1) Maintain and improve emergency responders' current Land Mobile Radio systems;

2) Ensure emergency responders and government officials plan and prepare for the adoption, migration, and use of broadband technologies, including the Nationwide Public Safety Broadband Network; and

3) Enhance coordination among stakeholders, specifically within processes and planning activities across the emergency response community.

For more information go to: http://www.dhs.gov/blog/2014/11/12/2014-national-emergency-communications-plan-sets-path-21st-century-public-safety

q) PSHSB Announces First Meeting of Optimal PSAP Architecture Task Force

The Federal Communications Commission's (FCC) Task Force on Optimal Public Safety Answering Point (PSAP) Architecture (Task Force) held its first meeting on January 26, 2015, at 1 p.m. in the Commission Meeting Room of the Federal Communications Commission, Room TW-C305, 445 12th Street SW., Washington, DC 20554. The Task Force is a Federal Advisory Committee that will study and report findings and recommendations on PSAP structure and architecture in order to determine whether additional consolidation of PSAP infrastructure and architecture improvements would promote greater efficiency of operations, safety of life, and cost containment, while retaining needed integration with local first responder dispatch and support.

r) CDC Maintains EMS Guidance on Approach to EVD

EMS agencies are encouraged to remain familiar with updated resources available from the Centers for Disease Control and Prevention related to EMS interactions with patients potentially infected with Ebola Virus Disease (EVD). The latest version of the guidance was recently updated to clarify the minimum personal protective equipment (PPE) levels for EMS personnel and first responders. The updated information reflects the PPE guidance described in CDC's:

1) Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Under Investigation for Ebola Virus Disease. Go to: http://www.cdc.gov/vhf/ebola/healthcare-us/emergency-services/emergency-departments.html

2) Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing). Go to: http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

3) Algorithm for Emergency Medical Services and 9-1-1 Public Safety Answering Points for Management of Patients Who Present with Possible Ebola Virus Disease in the United States. Go to: http://www.cdc.gov/vhf/ebola/pdf/ems-911-patients-with-possible-ebola.pdf.

s) Naloxone Legal Resources Released

The Network for Public Health Law has two new resources related to the use of Naloxone for opioid overdoses. *"Legal Interventions to Reduce Overdose Mortality: Emergency Medical Services Naloxone Access"* provides an overview of relevant laws and regulations for Emergency Medical Services naloxone access in all 50 states, D.C., Guam and Puerto Rico. Go to: https://www.networkforphl.org/_asset/8b7kmi/EMS-naloxone-overview.pdf.

"Using Law to Support Pharmacy Naloxone Distribution" explores the legal mechanisms for improved pharmacy distribution of naloxone, and helps public health professionals, prescribers, pharmacy managers, and local, and territorial health departments understand key legal issues. Go to: https://www.networkforphl.org/_asset/qdkn97/Pharmacy-Naloxone-Distributions.pdf

t) ATS Unveils Explanation of Trauma Center Capability

According to the American Trauma Society (ATS), trauma center levels across the United States are identified in two fashions by state designation process and a verification process. The different levels (ie. Level I, II, III, IV or V) refer to the kinds of resources available in a trauma center and the number of patients admitted yearly. These are categories that define national standards for trauma care in hospitals. Categorization is unique to both Adult and Pediatric facilities.

Trauma Center designation is a process outlined and developed at a state or local level. The state or local municipality identifies unique criteria in which to categorize Trauma Centers. These categories may vary from state to state and are typically outlined through legislative or regulatory authority.

Trauma Center Verification is an evaluation process done by the American College of Surgeons (ACS) to evaluate and improve trauma care. The ACS does not designate trauma centers; instead, it verifies the presence of the resources listed in Resources for Optimal Care of the Injured Patient. These include commitment, readiness, resources, policies, patient care, and performance improvement. The ATS offers a description that differentiates between Level I-V trauma centers that can be used to help educate the public. For more information go to: http://www.amtrauma.org/?page=TraumaLevels

u) Reminder: FDA Drug Shortages Index Has Migrated to New Page

Readers are reminded that the Food and Drug Administration (FDA) has migrated its "Current Drug Shortages Index" to: http://www.accessdata.fda.gov/scripts/drugshortages/default.cfm. Drug shortages and discontinuations reported to the FDA are listed with detailed information regarding product availability. Several medications in use by EMS agencies remain in short supply, including atropine sulfate, dextrose 5% bags, epinephrine, fentanyl , morphine sulfate, sodium chloride 0.9% injection bags, and more.

v) EMS Blogger Challenges States and Medical Directors to Rethink Approach to Epi Administration

While organizationally NASEMSO is not one to engage in online discussions, one particular post by Paramedic Chris Kaiser recently caught the eye of NASEMSO leadership. "Why do Ambulances Carry Epipens?" is a thoughtful view on the recent surge in the cost of Epipens® in light of efforts by advocacy groups to expand the availability of the device at the Basic Life Support level. In fact, some states DO permit EMT's to use Epipens® with special training although many EMS agencies are reluctant to stock them due to the expense, infrequent use, and relatively short shelf life.

While NASEMSO is not opining on EMT's giving epinephrine one way or the other, NASEMSO is impressed by the quality and professionalism displayed by one committed EMS practitioner as an example for others related to improving practice. So here's a "shout out" to Paramedic Kaiser, "trying to advance the idea that the Emergency Medical Services can be made into the profession that we all want it, need it, and know it deserves to be" for a job well done!! Check it out at *"Life Under the Lights"* at: http://www.lifeunderthelights.com/2014/12/22/why-do-ambulances-carry-epi-pens/#sthash.5el051Fz.0o3kC8bH.dpbs

Educational Development

III. Educational Development

Committees

A. **Training and Certification Committee** (TCC): The Training and Certification Committee met on Wednesday, January 7, 2015. There were no action items.

The committee is initiating a workgroup to research the various requirements and options necessary to assure continued access to an intermediate cognitive written examination if and when the National Registry discontinues offering the Intermediate 99 examination. The Office no longer writes EMS certification examinations because of the time and expense that goes into developing a validated, psychologically sound, legally defensible examination that complies with The National Commission for Certifying Agencies (NCAA) which is the accreditation arm of The National Organization for Competency Assurance (NOCA). The NCCA is recognized as the authority on accreditation standards for professional certification organizations and programs. NCCA accreditation means that the standards possessed by the accredited program have been reviewed by the NCCA and deemed credible for ensuring the health, welfare and safety of the public.

Copies of past minutes of TCC are available on the Office of EMS web page at: : http://www.vdh.virginia.gov/OEMS/Training/Committees-PDC.htm

B. **Medical Direction Committee (MDC)** The Medical Direction Committee met on Thursday, January 8, 2015. There are no action items for consideration.

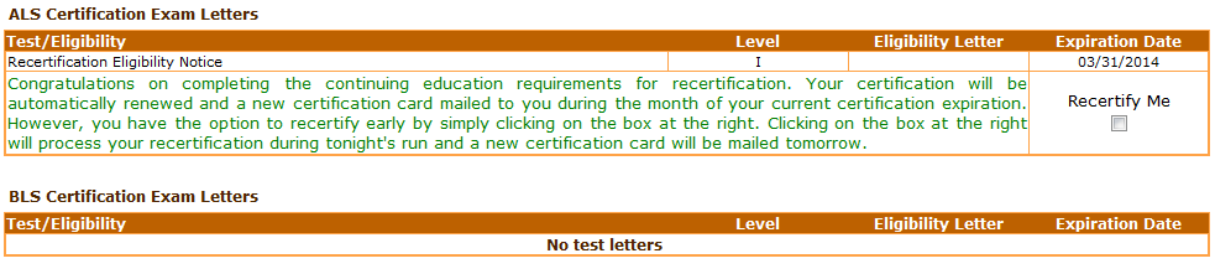
Copies of past minutes are available from the Office of EMS web page at: http://www.vdh.virginia.gov/OEMS/Training/Committees.asp

New EMS Certification Process effective March 1, 2014

As of March 1, 2014, the recertification process in Virginia has changed. Any provider, regardless of affiliation status, who receives recertification eligibility prior to their EMS certification expiration, will automatically be recertified during the month of their certification expiration. If the last continuing education (CE) is received in the month of their expiration, the process will automatically recertify the provider. There is no action required by the provider for this to occur, other than to assure their continuing education is received by the office prior to their certification expiration date. Submission of a "blue" form with an OMD test waiver signature is no longer required.

ALS –Coordinators and Emergency Operations Instructors will continue to recertify through their normal process.

The new process allows the provider to recertify early, should they choose to do so.
Once a provider has complied with all EMS recertification criteria prior to their certification expiration date, instead of an eligibility letter, the following notice will appear in their EMS portal:



ALS Certification Exam Letters

Test/Eligibility	Level	Eligibility Letter	Expiration Date
Recertification Eligibility Notice	I		03/31/2014
Congratulations on completing the continuing education requirements for recertification. Your certification will be automatically renewed and a new certification card mailed to you during the month of your current certification expiration. However, you have the option to recertify early by simply clicking on the box at the right. Clicking on the box at the right will process your recertification during tonight's run and a new certification card will be mailed tomorrow.			Recertify Me ☐

BLS Certification Exam Letters

Test/Eligibility	Level	Eligibility Letter	Expiration Date
No test letters			

By checking the "recertify me" box, the provider's certification will be processed in that night's batch process and a new EMS certification card will be issued the next day. This allows providers who wish to keep both their Virginia certification and their National Registry certification continuing education on the same rotation for recertification. Remember, as indicated in the first paragraph, this is optional. Regardless of whether or not you check the box, you will automatically be recertified during your certification expiration month if you are eligible.

(Hint – all Virginia providers whose National Registry certification is up for renewal in March 2015, are encouraged to manually recertify in March if you want to synchronize your two certifications.)

Important Note:

This change does not affect re-entry. If a provider's CE is not received in the office prior to the certification expiration date, regardless of when the class was taken, the provider reverts to re-entry status. There is no grace period for the submission of CE. Upon meeting eligibility to recertify criteria while in re-entry status, the provider must successfully pass a certification examination. A BLS provider will be required to pass both the Virginia psychomotor exam and the National Registry cognitive examination at their expense. ALS providers will be required to pass the National Registry cognitive assessment examination at their expense.

Providers, who obtained certification by legal recognition or are in the process of challenging Virginia EMT, must successfully complete the Virginia psychomotor exam and the National Registry cognitive examination at their expense after receiving an eligibility notice. The new recertification process does not apply if this is the first Virginia recertification for the provider who obtained their current certification through legal recognition; however, subsequent recertifications will follow the described "new" process.

As with any new program, there may be some unforeseen or untested situations. For those providers who are eligible for recertification and have not been recertified by the middle of the month of certification expiration, please contact the office.

Advanced Life Support Program

A. Virginia I-99 to Paramedic student's are continuing the transition process that allows them to gain certification at the Paramedic level after completion of a Virginia approved Intermediate-99 to Paramedic bridge program.

B. ALS Coordinator re-endorsement requires an update every two years and the submission of a re-endorsement application. The application must be signed by an EMS Physician. Additionally it must contain the signature of the regional EMS council director if courses are to be offered in their region.

C. Virginia certified providers who also maintain their National Registry certification will be able to recertify by selecting the traditional refresher course option on their recertification application. A statement will appear on their CE report that verifies they have completed a Virginia approved refresher course that meets the requirements established by National Registry for recertification. The CE must be obtained during their two-year certification cycle with National Registry to take advantage of this option. More information will be released in the near future.

Basic Life Support Program

A. Education Coordinator Institute

1. The Office will hold the first Education Coordinator Institute for 2015 , January 24-28 in the Tidewater Area.
2. The deadline to pass the EC Cognitive exam in order to be eligible for the next Institute is April 12, 2015. The next EC Psychomotor Exam is scheduled for May 9, 2015 in the Richmond Area.
3. The Next EC Institute is scheduled for June and will be held in Blacksburg in conjunction with the VAVRS Rescue College.
4. EMS Providers interested in becoming an Education Coordinator please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov
5. Schedule of the various deadlines and EC Institutes can be found on the OEMS website at: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. EMS Educator Updates:

1. For 2015, the Division of Educational Development continued to provide in-person Educator Updates.
2. The Office conducted an in-person EMS Instructor Update on Saturday, January 24th on the campus of Tidewater Community College in the TEMS Region.
3. The schedule of future updates can be found on the Web at: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm

EMS Training Funds

FY13

	Commit $	Payment $	Balance $
Emergency Ops Funding	$1,460.00	$755.00	$705.00
BLS Initial Course Funding	$729,348.00	$358,139.11	$371,208.89
BLS CE Course Funding	$125,160.00	$49,936.21	$75,223.79
ALS CE Course Funding	$297,360.00	$78,575.00	$218,785.00
BLS Auxiliary Program	$80,000.00	$18,280.00	$61,720.00
ALS Auxiliary Program	$350,000.00	$161,005.00	$188,995.00
ALS Initial Course Funding	$1,102,668.00	$588,894.99	$513,773.01
Totals	**$2,685,996.00**	**$1,255,585.31**	**$1,430,410.69**

FY14

	Commit $	Payment $	Balance $
Emergency Ops Funding	$1,120.00	$280.00	$840.00
BLS Initial Course Funding	$780,912.00	$371,354.12	$409,557.88
BLS CE Course Funding	$94,010.00	$36,648.02	$57,361.98
ALS CE Course Funding	$223,270.00	$79,415.00	$143,855.00
BLS Auxiliary Program	$130,000.00	$61,300.00	$68,700.00
ALS Auxiliary Program	$304,000.00	$178,690.00	$125,310.00
ALS Initial Course Funding	$1,188,504.00	$523,189.72	$665,314.28
Totals	**$2,721,816.00**	**$1,250,876.86**	**$1,470,939.14**

FY15

	Commit $	Payment $	Balance $
Emergency Ops Funding	$2,480.00	$180.00	$2,300.00
BLS Initial Course Funding	$592,888.50	$144,810.96	$448,077.54
BLS CE Course Funding	$53,609.00	$11,258.80	$42,350.20
ALS CE Course Funding	$129,622.50	$21,218.75	$108,403.75

BLS Auxiliary Program	$71,360.00	$3,920.00	$67,440.00
ALS Auxiliary Program	$424,240.00	$32,440.00	$391,800.00
ALS Initial Course Funding	$816,424.00	$178,028.28	$638,395.72
Totals	**$2,090,624.00**	**$391,856.79**	**$1,698,767.21**
	Commit $	**Payment $**	**Balance $**

EMS Education Program Accreditation

A. EMS accreditation program.
   1. Emergency Medical Technician (EMT)
      a) Frederick County Fire and Rescue will have their site visit in March.
      b) Harrisonburg Rescue Squad has submitted their self-study. It is been assigned to a site visit team.
      c) Chesterfield Fire/EMS has submitted their self-study. It has been assigned to a site visit team.
   2. Advanced Emergency Medical Technician (AEMT)
      a) Frederick County Fire and Rescue will have their site visit in March.
   3. Intermediate – Reaccreditation
      a) Roanoke Valley Regional Fire/EMS Training Center reaccreditation is under review by a site team and will be scheduled for their reaccreditation visit in the near future.
   4. Intermediate – Initial
      a) Southwest Virginia EMS Council has been granted conditional accreditation with review. Their initial Intermediate course will begin in early spring.
      b) Paul D. Camp Community College will have their initial accreditation visit in February.
   5. Paramedic – Initial
      a) Patrick Henry Community College has been granted full accreditation with CAAHEP.
      b) Lord Fairfax Community College has been granted full accreditation from CAAHEP.
      c) Germanna-Rappahannock EMS Council's initial accreditation visit is scheduled for February 17-18, 2015.
   6. Paramedic – Reaccreditation
      a) Piedmont Virginia Community College is scheduled for a CoAEMSP reaccreditation visit on January 29 & 30, 2015.

B. For more detailed information, please view the Accredited Site Directory found on the OEMS web site at:
   1. http://www.vdh.state.va.us/OEMS/Training/Accreditation.htm

C. Beginning January 1, 2013, students must enroll in a nationally accredited paramedic program to qualify for National Registry certification. National accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).

1. Virginia paramedic training programs in the Commonwealth have met the requirements making their students eligible to test NREMT as of January 1, 2013.

2. The following programs still need to obtain national accreditation through CoAEMSP/CAAHEP.
    a) Prince William County Paramedic Program
    (1) Has received their Letter of Review from CoAEMSP and have completed their first cohort class. They have submitted their Initial-Accreditation Self Study Report (ISSR) and are awaiting further information from CoAEMSP.

National Registry

Effective, January 1, 2017, the NREMT will be increasing the initial certification fees. The NREMT Board of Directors approved the fee increase effective 2017 following a ten-year price freeze (2007 -2017). A portion of the 2017 fee increase reflects the renewed relationship between the NREMT and Pearson VUE. See **Appendix C**.

On Line EMS Continuing Education

Distributive Continuing Education

EMSAT programs are available FREE on the Internet. Certified Virginia EMS providers can view EMSAT continuing education courses at no cost while at home or work. Fifty to sixty EMSAT programs are available on CentreLearn Solutions LLC, at no cost to Virginia EMS providers. For specifics, please view the instructions listed under Education & Certification, EMSAT Online Training. For more information on EMSAT, including schedule and designated receive sites, visit the OEMS Web page at:
http://www.vdh.virginia.gov/OEMS/Training/WebBasedCE.htm

EMSAT

EMSAT programs for the next three months include:

Feb. 18, Advances in Hospital CPR
Instructor: Dr. Joseph Ornato, MCVH-VCU
Cat. 1 ALS, Area 72, Cat. 1 BLS, Area 05

Mar. 18, On Scene Challenge: Airway
Various agencies involved
Cat. 1, ALS, Area 88, Cat. 1 BLS, Area 03

Apr. 15, Neonatal Resuscitation
Dr. Russell Moores, MCVH-VCU
Cat. 1 ALS, Area 91, Cat. 1 BLS, Area 08

The EMS Portal

OEMS released the portal for EMS physicians this past spring. This component provides EMS physicians with unprecedented access to their agencies, providers, courses, education coordinator endorsements, educational program statistics and the status of their re-endorsement status. All current EMS physicians should have received an email with information about how to access the portal. Any concerns or issues related to gaining access to the portal should be directed to Warren Short or Mike Berg.

As a reminder, the EMS Portal is an all encompassing electronic dossier which provides Virginia's EMS personnel with unrivaled, 24/7/365 access to:

- EMS Agency affiliation data
- Continuing Education (CE) reports
- Enrolled course data
- Certification Test Eligibility letters
- Certification Test Results
- E-mail notifications of certification expiration
- Access to update/change address, phone number and e-mail address
- E-mail opt-in/opt-out functionality allowing for updates from various Divisions within the Office of EMS.

Please be sure to keep your email up to date and assure it is listed correctly in the portal.

CTS

A. There have been 38- CTS, 1- EMT accredited course and 2- ALS psychomotor test sites conducted from November 5, 2014 through January 14, 2015.

B. Examiner William Streett has resigned. Interviews for two new examiners in Northern Virginia will begin soon.

C. The TCC workgroup developing an updated CTS evaluator training program has completed a narrated PowerPoint presentation. It will be available on CentreLearn soon.

Other Activities

- The Office has prepared a report on EMS Providers based on level of certification by Council, Planning District, and Agency. See **Appendix D**.

- Debbie Akers continues to participate on the NASEMSO's Community Paramedicine Insights Forum webinars.

- Debbie Akers is serving as the staff liaison to a Mobile Integrated Healthcare workgroup. The workgroup has representation from the following: Fire based EMS, EMS OMD, ED Physician, EMS Administrator, EMS Provider, Regional Councils, Hospital ACA, Pediatrics, Commercial EMS, VDH Licensure, Primary Care Physician, VHHA, DMAS, Va Association for Home Care and Hospice and the VA Association for Hospices and Palliative Care. The workgroup is being chaired by Dr. Allen Yee. An initial meeting will take place on Thursday, February 12 at 2 PM at the Courtyard Marriott in Glen Allen.

- Warren Short continues to participate on the NASEMSO's Education and Professional Standards Committee's (EPSC) monthly conference calls.

- Warren Short participated in a meeting of the Atlantic EMS Councils EPSC committee December 1 through December 3.

Emergency Operations

IV. Emergency Operations

Operations

- **Virginia 1 DMAT**

Frank Cheatham, HMERT Coordinator continues to attend Va-1 DMAT meetings as a representative of the Office of EMS. The December Leadership meeting was held at the Office of EMS.

- **Ebola Preparedness**

The Division of Emergency Operations continued to update and distribute messaging for information to EMS agencies, providers, and PSAPs pertaining to the worldwide Ebola outbreak throughout the months of November through January. Information is being shared through outreach using email and social media in concert with the VDH Office of Epidemiology. Special thanks are due to Winnie Pennington, Emergency Planner, for her hard work on this effort.

Karen Owens, Emergency Operations Manager, Constance Green, Assistant Operations Manager, and Winnie Pennington, Emergency Operations Planner, attended various meetings regarding Ebola planning and preparedness in Virginia, including the bi-weekly IMT meetings, the OCME Ebola Planning Meeting on November 7, 2014 and multiple TTX Planning meetings.

- **2014 Virginia EMS Symposium**

The 2014 Virginia EMS Symposium was held on November 4-9 at the Norfolk Waterside Marriott and the Norfolk Waterside Sheraton. The OEMS Operations Division staff all attended and provided support for the 2014 EMS Symposium. Frank Cheatham, HMERT Coordinator, was Logistics Section Chief for the Annual EMS Symposium. He coordinated various aspects of the event and also held several planning meetings to recap the event and begin planning for 2015. Cross agency meetings were held to solicit input for improving the event and task management for the coming year. Kenneth Crumpler, Emergency Operations Communications Coordinator, managed the Communications unit. Winnie Pennington, Emergency Operations Planner, Karen Owens, Emergency Operations Manager and Connie Green, Emergency Operations Assistant Manager, also provided staff support.

Kenneth Crumpler, Emergency Operations Communications Coordinator, taught “The Field Responders Guide to Motorcycle Crashes” and “The PSAP’s Role in a Mass-Casualty Incident” classes. He also established and managed the Communications unit of the Symposium.

Karen Owens, Emergency Operations Manager, Connie Green, Emergency Operations Assistant Manager, and Frank Cheatham, HMERT Coordinator, taught “Mass Casualty Incident Management I and II” and “Mass Casualty Train-the-Trainer” classes.

Committees/Meetings

- **EMS Communications Committee**

The EMS Communications Committee did not meet on Thursday, November 6th 2014 at the Virginia EMS Symposium due to a lack of a quorum.

- **OEMS Public Safety Answering Point (PSAP) & 911 Center Accreditation**

PSAP Accreditation applications for Madison Co. 911 and Dickenson Co. 911 have been received and will be presented to the Communications Committee at the next scheduled meeting.

- **Provider Health and Safety Committee**

Karen Owens, Division Manager and Connie Green, Assistant Manager, attended the Provider Health and Safety Committee meeting on December 17, 2014. The committee discussed the definition of abandonment with regards to provider safety, reviewed the Safety Bulletin rollout plan, discussed the vicarious trauma toolkit and planned their agenda for the coming year.

- **FARC Committee**

Karen Owens, Division Manager, Connie Green, Assistant Manager, Frank Cheatham, HMERT Coordinator, and Kenneth Crumpler, Communications Coordinator, attended the FARC Committee meeting on November 4-5, 2014 to provide input for the grant evaluation discussion.

- **Traffic Incident Management (TIM)**

The HMERT Coordinator continues to work with the TIM program. He continues work on the Job Aid Draft that was approved by the Statewide TIM Committee. The Best Practices Workgroup continues to gather information for their next meeting.

- **Lane Reversal Coordination**

Frank Cheatham continues to attend meetings in regards to Lane Reversal. He continues to look at various means of supporting the mission should OEMS be called on.

- **Task Force Meetings**

The HMERT Coordinator continues to field questions from the field about Task Force teams. There are several areas that are working on becoming one of the types of Task Forces to become a part of the system.

- **Unmanned Aircraft Workshop**

Frank Cheatham, HMERT Coordinator, attended a conference at Fort Pickett on the use of DRONES in the Emergency Services field. This meeting brought all aspects of the industry to the table to discuss the state of the industry and where it is headed. Information was presented regarding current and anticipated rules and regulations and an operational demonstration revealed tactical considerations as well..

- **COOP Committee**

Winnie Pennington, Emergency Operations Planner, met with COOP Committee on December, 16, 2014 to review the COOP Exercise AAR and plan for implementation of the Improvement Plan. Karen Owens, Division Manager and Connie Green, Assistant Manager, also participated in the meeting.

- **VDH Continuity Planning**

Winnie Pennington, Emergency Operations Planner, attended the VDH Continuity Planning meeting for Offices on January 9, 2015 where she obtained direction on improving the COOP for the Office of EMS.

- **VDH Patient Tracking Workgroup**

Winnie Pennington, Emergency Planner, attended the VDH Patient Tracking Workgroup meeting on December 18, 2014.

- **Ambulance Service Australia visit**

On Monday, Jan 12, 2015 the Office of EMS, in coordination with the Richmond Ambulance Authority (RAA), welcomed Clinical Director Michael Rigo and Critical Care Paramedic Mick Hourigan to Richmond. Both guests were members of Ambulance Service Australia and are based in Canberra, Australia. As a part of their four-day visit the guests were led on a tour of the Office of EMS by Ken Crumpler, Emergency Operations Communications Coordinator. They were provided an overview of the Virginia EMS system and discussed similarities and differences with that of the Australian EMS System. Many thanks go to additional staff members who participated in Mr. Rigo and Mr. Hourigan's visit to the OEMS: Scott Winston, Assistant Director; Warren Short, EMS Training Manager; Terry Coy, Media Specialist III; Constance Green, Emergency Operations Assistant Manager; Winnie Pennington, Emergency Operations Planner; Frank Cheatham, HMERT Coordinator; Michael Berg, Regulations and Compliance Manager; and Paul Sharpe, Trauma and Critical Care Manager.

Training

- **Continuity of Operations Exercise**

Winnie Pennington, Emergency Operations Planner, completed the After Action Review for the 2014 OEMS Office COOP Exercise, summarizing successes and areas for improvement in the OEMS COOP Plan to be addressed by the OEMS COOP Committee in 2015.

- **Traffic Incident Management**

Frank Cheatham, HMERT Coordinator, helped instruct the January 18, 2015 Traffic Incident Management (TIM) class in South Hill. Over 20 students attended representing EMS, Fire, Law Enforcement and the Towing industry. Instruction covered improving scene safety and reducing risk through effective management of traffic incidents and students participated in cross-discipline tabletop exercises in addition to lectures.

Communications

- **The Association of Public Safety Communications Officers (APCO) and National Emergency Number Association (NENA)**

Kenneth Crumpler, Emergency Operations Communications Coordinator, participated in a teleconference, sponsored by the Va. Dept. of Education, on December 9, 2014 with representatives from the Virginia chapters of APCO and NENA. Topics included a plan to introduce emergency dispatch training in Virginia high schools, similar to the EMT classes that are currently being offered. It was recommended that the focus should be on basic emergency telecommunications and not Emergency Medical Dispatch. OEMS offered to assist as appropriate as the program moves forward.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

During this reporting quarter Regional Council CISM teams reported 10 events, including education sessions, training classes, and debriefings (both group and one-on-one).

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

Regional EMS Councils

FY15 Second Quarter contract reports have been submitted by the Regional EMS Councils throughout the month of January and are currently under review.

The EMS Systems Planner attended the Old Dominion EMS Alliance and Northern Virginia EMS Council board meetings, as well as the funeral services for former ODEMSA Executive Director Jon Donnelly in the quarter.

Medevac Program

The Medevac Committee is scheduled to meet on February 12, 2015. The minutes of the November 5, 2014 meeting are available on the OEMS website at http://www.vdh.virginia.gov/OEMS/AdvisoryBoard/Committees/Medevac.htm

The Medevac Helicopter EMS application (formerly known as WeatherSafe continues to grow in the amount of data submitted. In terms of weather turndowns, there were 572 entries into the Helicopter EMS system in the fourth quarter of 2014. 66% of those entries (378 entries) were for interfacility transports, which is consistent with information from previous quarters. The total number of turndowns is a decrease from 612 entries in the fourth quarter of 2013. For the 2014 calendar year, there were 2,252 total entries into the system, a decrease from 2,416 entries for the same timeframe in 2013. This data continues to show a commitment on the part of medevac programs to maintaining the safety of personnel and equipment.

On February 21, 2014, The Federal Aviation Administration (FAA) released new rules and regulations governing Helicopter Air Ambulance Operations. These regulations were to be implemented on April 22, 2014. On April 21, 2014, the FAA released notification that the implementation date had been extended to April 22, 2015. This will allow certificate holders sufficient time to implement the new requirements based on the regulations.

The EMS Systems Planner also participates on the NASEMSO Air Medical Committee. The committee met on January 29, 2015.

OEMS and Medevac stakeholders continue to monitor developments regarding federal legislation and other documents related to Medevac safety and regulation.

State EMS Plan

The Virginia Office of EMS Strategic and Operational Plan is mandated through *The Code of Virginia* to be reviewed and revised on a triennial basis. The current version of the plan was approved by the State Board of Health on June 5, 2014.

The current version of the State EMS Plan is available for download via the OEMS website at http://www.vdh.virginia.gov/OEMS/EMSPlan/index.htm .

Public Information and Education

VI. Public Information and Education

Public Relations

Promotions

Via Press Release

Garnered the following media coverage for the Governor's EMS Awards press release that was sent out Nov. 18, 2014:

- News Leader, November 18, 2014, http://www.newsleader.com/story/news/2014/11/18/local-ems-director-wins-governors-award/19240069/

- SWVA Today, November 19, 2014, http://www.swvatoday.com/news/bland_county/article_e20befbe-6f5e-11e4-895c-abfc1f6d19e4.html

Via EMS Bulletin

- Completed the Fall/Winter EMS Bulletin and posted online November 21, 2014.

- It was one of the top most downloaded items in November and December.

Via Constant Contact E-mail Listserv (October - December)

- **October 15** – Ebola Update to Providers
- **October 22** – Governor's EMS Awards Invitation to Nominees
- **October 28 –** Ebola Update to Providers
- **November 19 –** Governor's EMS Award Winners
- **November 24** – Winter EMS Bulletin
- **December 2 –** Call for Presentations reminder
- **December 4** – 2015 Symposium lodging

Via Social Media Outlets

We continue to keep OEMS' Twitter and Facebook pages active, educational and relevant by posting daily and/or weekly updates that provide important announcements and health-related topics to increase awareness and promote the mission of OEMS and VDH. Some of the subjects that were featured from October - December are as follows:

- **October –** Interim Guidance for EMS Systems and 911 Public Safety Answering Points for Management of Patients with Known or Suspected Ebola Virus Disease in the U.S., last day to register for the Va. EMS Symposium, Ebola video update from the Virginia State Health Commissioner Dr. Marissa Levine and State Epidemiologist Dr. Laurie Forlano, holiday office closures, Ebola Virus Disease Update for EMS Providers, Ebola FAQs, CDC guidance for enhanced personal protective equipment (PPE), Tidewater EMS Council Basic, Advanced, Update and Train-the-Trainer OHSA Infectious and Designated Officer courses, Ebola update for EMS providers, Ebola update video from Virginia State Health Commissioner Dr. Marissa Levine.

- **November –** Virginia EMS Symposium, Symposium Food vendors info, On-site Guide, CISM Meet and Greet, Symposium Exhibit Hall hours, box lunches, Casino Monte Carlo, bingo prize winners, Governor's EMS Awards, 2014 Governor's EMS Award winners press release, memorandum regarding the elimination of the requirement to obtain a medical practitioner's signature, 2015 Call for Presentations, EMS Bulletin, Winter Preparedness Week, holiday office closures, food safety tips.

- **December –** 2015 Norfolk Waterside Marriott and the Sheraton Norfolk Waterside room block reservation info, CDC guidance for EMS and PSAPS, Tidewater CISM Team will be hosting a CISM and Stress Management Conference, "Taking Care of our Own: CISM and Beyond, Tidewater Community College (TCC) and Thomas Nelson Community College (TNCC) EMT/Intermediate/Paramedic program, holiday office closures, space heater safety procedures.

Customer Service Feedback Form (Ongoing)

- PR assistant provides monthly reports to EMS management regarding OEMS Customer Service Feedback Form.

- PR assistant also provides weekly attention notices (when necessary) to director and assistant director concerning responses that may require immediate attention.

CommonHealth Wellnotes (Ongoing)

On a weekly basis, the PR assistant forwards the CommonHealth Wellnotes to OEMS staff as the CommonHealth Coordinator.

Governor's Weekly Report (Ongoing)

On a weekly basis, the PR coordinator sends out information on behalf of OEMS for the Governor's Weekly Report. The purpose of the Weekly Report is to provide the Governor's Office with brief bullet points highlighting significant issues and activities that have occurred during the past week – reflecting both positive agency accomplishments as well as ongoing challenges/opportunities.

Social Media and Website Statistics

Figure 1: This graph shows the total organic reach of users who saw content from our Facebook page, October - December 2014. Each point represents the total reach of organic users in the 7-day period ending with that day.

Organic reach is the number of unique people who saw our post in the newsfeed or on our page, including people who saw it from a story shared by a friend when they liked it, commented on it, shared our post, answered a question or responded to an event. Also includes page mentions and check-ins. Viral reach is counted as part of organic reach.

***As of January 27, 2015, the OEMS Facebook page had 4,231 likes, which is an increase of 255 new likes since October 20, 2014. It's important to note that as of October 26, 2014, our Facebook page officially reached 4,000 likes! As of January 27, 2015, the OEMS Twitter page had 3,029 followers, which is an increase of 141 followers since October 20, 2014.**

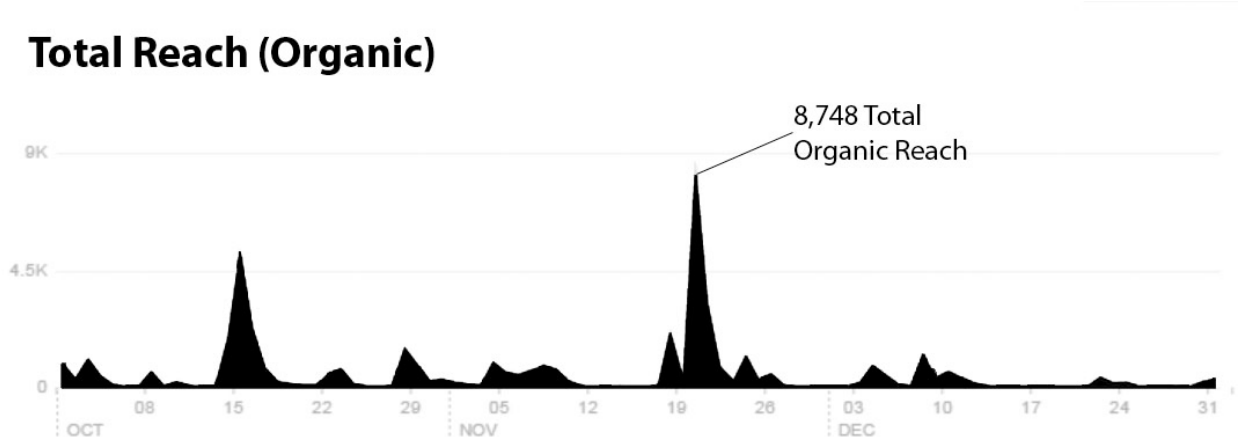


Figure 2: This table represents the top five downloaded items on the OEMS website from October – December.

October	1. 2014 Virginia EMS Symposium Catalog (45,909) 2. 2010 Presentations - LMGT-732 (27,442) 3. EMSAT Centrelearn Instructions (18,257) 4. Emergency Operations/EbolaCDCGuidelines10-27-14 (7,080) 5. 2012 EMS Regulations (5,836)

November	1. EMS Fall/Winter Bulletin (73,492) 2. 2014 Virginia EMS Symposium Catalog (27,662) 3. 2010Presentations - LMGT-732 (20,767) 4. EMSAT Centrelearn Instructions (16,505) 5. 2013 Presentations - AIR-202 (8,977)
December	1. 2010 Presentations - LMGT-732 (27,228) 2. EMSAT Centrelearn Instructions (18,466) 3. EMS Fall/Winter Bulletin (15,354) 4. 2012 Presentations - OPE-4006 (7,491) 5. 2013 Presentations - PRE-006-EMSFICS-StudentManual (7,228)

Figure 3: This table identifies the number of unique visitors, the average hits per day and the average visit length by minutes to the OEMS website from October – December. *Visitors* are defined as the number of unduplicated (counted only once) visitors to your website over the course of a specified time period, whereas the *average hits per day* include both unique visitors and repeat visitors.

	Visitors	Average Hits Per Day	Average Visit Length (Minutes)
October	92,619	2,987	11:56
November	89,959	2,998	15:50
December	83,892	2,706	16:37

EMS Symposium

- PR coordinator continued to update Symposium sponsor's website info to be posted on the OEMS website.
- PR assistant created the sponsor bingo card and printed 1,800 copies for symposium bags. Karen Owens, emergency operations manager coordinated and obtained bingo and symposium event prizes from various symposium vendors and local retailers.
- PR coordinator printed all symposium registration packet letters.
- PR assistant coordinated the printing of registration name badges.
- PR coordinator managed all handouts (from sponsors and OEMS staff) to be included in the registration packets. The last week in October, stuffed and packed 1,800 registration packets.
- Attended the 35th Annual Virginia EMS Symposium, November 5-9, 2014. Assisted with registration and signage, coordination of the Governor's EMS Awards ceremony and reception, the flu shot clinic and other evening events. Assisted with the vendor hall and updated social media sites with classroom/instructor updates and other event info.
- PR assistant emailed Leadership and Management honorary certificates in December to eligible Symposium attendees who signed up and met the certificate requirements.

Governor's EMS Awards Program

- PR assistant prepared award winner's info, which was read at the award ceremony, and also prepared the award nominee PowerPoint presentation.
- PR assistant emailed nominees electronic invitation to the awards ceremony and reception, and also monitored nominee's RSVP to the award reception.
- PR coordinator posted the Governor's EMS Award winners on the OEMS website homepage.
- On November 18, 2014, PR coordinator prepared press release announcing state award winners and also prepared the winner's bio write-up to be posted on OEMS website.
- PR coordinator promoted award winners through Facebook and Twitter social media sites
- Sent email through the OEMS listserv recognizing the 2014 Governor's EMS Award winners.
- Emailed press release info and bio write-up to the Regional EMS Councils for local recognition at the regional level.
- PR assistant coordinated meeting to discuss the 2015 Governor's EMS Awards program and updating the forms for the new year.

Media Coverage

The PR coordinator was responsible for fielding the following OEMS media inquiries October - December:

- Oct. 9 – Received an inquiry from The News & Advance regarding Drug Box Diversions in the Western Virginia and Blue Ridge Region.
- Oct. 9 – Received an inquiry from Scripps' Washington Bureau regarding a records request for Trauma Centers.
- Oct. 22 – Received an inquiry from the Daily Press requesting information regarding medevac services, annual stats, billing, fly rules, etc.
- Nov. 3 – Received a follow-up inquiry from The News & Advance regarding the reporting of drug box diversions.
- Nov. 17 – Received an inquiry from the Wytheville Enterprise regarding the Governor's EMS Award winners in the Southwest region.
- Nov. 19 – Received an inquiry from the News Leader regarding the Governor's EMS Award winner in the Central Shenandoah region.
- Dec. 8 – Received an inquiry from the Daily Press regarding the availability of the Stroke Triage Plans and Virginia Trends in Trauma and Emergency Medicine report.

VDH Communications

VDH Communications Tasks– The PR coordinator was responsible for covering the following VDH communications tasks from October – December:

- **October** – Responsible for the Media Alerts task for the month of October. Collected news stories that mentioned VDH personnel or programs and emailed them to key staff every morning.
- **November** – Responsible for back up to all PR coordinators, which included covering Media Alerts, VDH in the News and fielding media calls.
- **VDH Communications Conference Calls (Ongoing) -** The PR coordinator participates in bi-weekly conference calls and polycoms for the VDH Communications team.

Commissioner's Weekly Email – The PR coordinator submitted the following OEMS stories to the commissioner's weekly email. Submissions that were recognized appear as follows:

October 6 - Office of EMS' New Web-Based Grant System a Success
The Office of Emergency Medical Services (OEMS) has implemented a new EMS-Grant Information Funding Tool (E-Gift), a web-based Rescue Squad Assistance Fund (RSAF) grant system. This program completely automates and integrates all phases of the grant process, including grant submission, grading and awards. The first phase was developed in three months and has been a huge success with the completion of the first grant cycle in September. Approximately 125 applications for financial assistance were submitted, with the requested amount totaling $8,914,211. The Grading Module was rolled out Oct. 1 and the Awards Module will be rolled out through November. The success of this project would not have been possible without the hard work and dedication of the Office of Information Management's (OIM) leadership: Debbie Condrey, chief information officer; Diana Malik, software development manager; Dheeraj Katangur, technical project manager, and Manoj Madhavan, technical lead. Thanks also to OIM support staff Tracy Mason, business analyst/user liaison; Sudheer Dadivela, Oracle developer, and Kapil Daddikar. Additional thanks to the OIM Database Administrators, Application Help Desk and Change Management teams for their support with his project. Special thanks to OEMS leadership – Gary Brown, director; Scott Winston, assistant director, and OEMS support staff – Amanda Davis, grants manager; Linwood Pulling, grants assistant; and Dennis Molnar, business manager.

October 14 - Office of EMS Receives National Awards

The National Association of State Emergency Management Services Officials' (NASEMSO) Abstract Review Team recently announced that two Office of EMS poster abstracts received awards in the association's poster competition. The OEMS poster abstract "Improving the Quality of Data Submitted by EMS Providers in Virginia" won third place and its poster abstract "Comparison of CDC Step 1 Field Trauma Triage Criteria and Patient Destination using EMS and Trauma Registry Data" was awarded an honorable mention. The goal of the NASEMSO-sponsored poster competition is to foster and develop system research and performance assessment, and improvement skills in state offices of EMS and trauma. Posters were required to describe, analyze, intervene and measure a system performance improvement topic. The top abstracts were announced at the opening session of NASEMSO's 2014 meeting in Cleveland October 6 – 10. Congratulations and special recognition for these awards goes to Informatics Coordinator Carol Pugh and Trauma and Critical Care Manager Paul Sharpe.

November 24 - OEMS Hosts 35th Annual Virginia EMS Symposium

The VDH Office of Emergency Medical Services (OEMS) hosted the 35th Annual Virginia EMS Symposium. The largest EMS training event in the state, and one of the largest in the country, welcomed 1,732 registered attendees. The symposium offered 18 course tracks and 279 courses covering everything from hands-on training in trauma, medical and cardiac care to education for Medevac services, pediatrics, communications, operations, and health and safety. Approximately 25,000 hours of continuing education credits were granted. The event also included the Governor's EMS Awards as well as a two-day rescue camp for children ages 8 – 12, who learned basic lifesaving skills.

Many thanks to the entire OEMS staff whose assistance and dedication make this event a continued success. Special thanks go to **Gary Brown**, director; **Scott Winston**, assistant director; **Warren Short**, EMS training manager; **Dr. George Lindbeck**, state operational medical director; **Debbie Akers**, ALS training specialist; **Frank Cheatham**, HMERT coordinator; **Terry Coy**, media specialist III; **Tristen Graves**, public relations assistant; **Irene Hamilton**, executive secretary; **Adam Harrell**, training and development specialist; **Norma Howard**, continuing education coordinator; **Marian Hunter**, public relations coordinator; **Greg Neiman**, BLS (basic life support) training specialist; and **Karen Owens**, emergency operations manager, for their preplanning, event coordination and on-site assistance.

Thanks also to the following for their support: **Michael Berg**, **Wayne Berry**, **Peter Brown**, **James Burch**, **Pat Couser, Ken Crumpler**, **Kapil Daddikar**, **Sudheer Dadivela**, **Ed Damerel**, **Amanda Davis**, **David Edwards**, **Paul Fleenor**, **Constance Green**, **Bryan Hodges**, **Ora Shea Jones**, **Dheeraj Katangur**, **Ron Kendrick**, **Stephen McNeer**, **Manoj Madhavan**, **Tracy Mason, Dennis Molnar, Carol Morrow**, **Kimberly Owens**, **Winnie Pennington**, **Tim Perkins**, **Heather Phillips**, **Carol Pugh**, **Karen Rice**, **Paul Sharpe**, **Wanda Street**, **Robert Swander** and **Nikki Tolliver**.

Regulation and Compliance

VII. Regulation and Compliance

Agency/Provider Compliance

The EMS Program Representatives continue to complete ongoing investigations pertaining to EMS agencies and providers. These investigations relate to issues concerning failure to submit prehospital patient care data and/or quality (VPHIB), violation of EMS vehicle equipment and supply requirements, failure to secure drugs and drug kits, failure to meet minimum staffing requirements for EMS vehicles and individuals with criminal convictions. The following is a summary of the Division's activities for 2014:

Compliance

Enforcement	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Citations	**12**	**20**	**6**	**2**	**40**
Agency	5	12	3	2	22
Provider	7	8	3	0	18
Verbal Warning		**14**	**7**	**0**	**21**
Agency		5	6	0	11
Provider		9	1	0	10
Correction Order		**46**	**13**	**0**	**59**
Agency		46	13	0	59
Provider		0	0	0	0
Temp. Suspension	**8**	**8**	**4**	**0**	**20**
Agency		0	0	0	0
Provider		8	4	0	12
Suspension	**5**	**3**	**0**	**3**	**11**
Agency		0	0	1	1
Provider		3	0	2	5
Revocation	**1**	**3**	**1**	**2**	**7**
Agency		0	0	0	0
Provider		1	1	2	4
Compliance	**30**	**109**	**48**	**15**	**202**

Cases					
Opened	14	87	30	9	140
Closed	16	22	18	6	62
Drug Diversions	**4**	**10**	**4**	**3**	**21**
Variances	**6**	**5**	**8**	**10**	**29**
Approved	3	4	5	4	16
Denied	3	1	3	6	13

Hearings

October 16, 2014 - Gallardo

Licensure

Licensure	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Agency	680	674	673	670	
New	3	1	4	1	9
Vehicles	4,400	4,455	4,439	4,346	
Inspection					
Agency	72	85	68	64	289
Vehicles	701	463	712	385	2,261
Spot	127	120	106	94	447

Background Unit

The Office of EMS has begun the process of conducting criminal history records utilizing the FBI fingerprinting process through the Virginia State Police effective July 1, 2014. A dedicated section of the OEMS website has updated and relevant information on this new process can be found at the following URL: http://www.vdh.virginia.gov/OEMS/Agency/RegCompliance/CriminalHistoryRecord.htm.

Background Checks		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Processed			248	1,387	1,853	3,488
Eligible				1,132	1,551	2,683
Non-Eligible			4	11	4	19
Outstanding			1	240	298	546

Regulatory

OEMS staff continues to work with the various EMS stakeholder groups to review suggested revisions to sections of the current EMS Regulations. Once completed, the suggested revisions will be forwarded to the Rules and Regulations Committee to be submitted as a regulatory review packet.

- The Fast Track Regulatory Packet for changes to the Financial Assistance to EMS agencies (FARC) is within the regulatory process and currently is at the Office of the Attorney General for their review and actions (http://townhall.virginia.gov/L/viewstage.cfm?stageid=6969)

- A Fast Track regulatory package to include the terminology of "affiliation" in the language of 12VAC-5-31-910 is within the regulatory process and currently is at the Secretary of Health and Human Resources for their review and actions (http://townhall.virginia.gov/L/viewstage.cfm?stageid=7067)

EMS Physician Endorsement

Endorsed EMS Physicians: As of January 27, 2015: 211

The first OMD workshop of the training year occurred on Norfolk, VA at the Virginia EMS Symposium (November 2014). A course was also conducted at the joint PEMS/TEMS Medical Direction Committee meeting on December 11, 2014. A complete listing of upcoming courses can be located on the OEMS webpage at the following URL: http://www.vdh.virginia.gov/OEMS/MedicalDirectors/CEWorkshops.htm. Registration is not mandatory, but strongly encouraged.

Additional Division Work Activity

The Regulation and Compliance staff held their quarterly staff meeting on December 3-5, 2014 in conjunction with the semi-annual FARC meeting and grant review process.

OEMS staff continues to offer technical assistance and educational presentations to EMS agencies, entities and local governments as requested:

- October 14, 2014 – Virginia Beach EMS – EMS Regulations presentation
- October 22, 2014 – Russell County officials /OMD(s) work session
- December 14-16, 2014 – Giles County Fire/EMS Study

Field staff continues to assist the OEMS Grants Manager and the RSAF program by performing reviews for submitted grant requests as well as ongoing verification of RSAF grants awarded each cycle.

Staff continues its work at the national level in the development of ambulance standards:

CAAS GVS 2015:

Public comment period concluded for draft document. A meeting has been scheduled for February 6, 2015 to review comments and make any recommended changes. It is anticipated the CAAS Board of Directors will approve the final document at their May 2015 meeting with an implementation date of October 1, 2015.

NFPA 1917

Ballots have been released for the technical review committee and collected regarding changes for the upcoming version II for the NFPA 1917 Standards for Automotive Ambulances. The earliest the 2016 edition could be published would be May 2015 and the latest would be August 2015; the document would carry a 2016 edition date with an effective date of January 1, 2016.

OEMS staff is working with the Transportation Committee to review and submit recommendations to be considered for adoption as "Virginia" specific requirements.

OEMS staff continues to work with Dr. Mark Kirk, M.D. at UVA and Virginia Paramedic Rita Krenz as prehospital provider/reviewers with the National Library of Medicine/National Institute of Health in the development of a first responder/first receiver product with smart phone application. This team has meet via webinar and conference calls. It is anticipated this product will be released in 2015.

Additional Personnel Matters

Please welcome a new team member to the Regulation and Compliance Division, Mr. Scotty Williams. Scotty started in December and will be the EMS Program Representative for the NOVA service area. Scotty, a Virginia certified Paramedic, comes to us with a rich history in the Northern Virginia area as he retired from one of the jurisdictional agencies as the EMS chief, migrated to upstate New York for a stint with a career fire department and now resides in Front Royal, VA with his family.

Please welcome Doug Layton, another new team member for the Division of Regulation and Compliance. Doug is filling the vacancy left by former program representative Romney Smith covering CSEMS, TJEMS and parts of BREMS. With Doug's addition, we will once again be at full staffing!

Doug is a life member of the Charlottesville-Albemarle Rescue Squad and is a Virginia certified Paramedic. He comes to us with a strong customer service background as a service advisor for a local car dealership and a sales representative for a large pharmaceutical company. Doug and his wife Heather have two young boys (Hunter and Connor) and reside in Albemarle County.

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee last met on November 6, 2014. The committee's primary goal is to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

The EMS Officer Sub-committee has met several times since the last State EMS Advisory Board meeting. The sub-committee has been working on developing an EMS Officer I course based on the Fire Officer I course material in the Jones and Bartlett Fire Officer Principles and Practice (Third Edition). This course will require the student to do reading, home work assignments and projects prior to each class. The hybrid course will require approximately 24 hours of actual class time.
There will be 2 EMS Officer I program pilots – Tentatively scheduled, as follows:

- Richmond area : March 24-April 14, 2015 on Tuesday evenings and Saturdays.
- Northern Virginia area: March 23 – April 13, 2015 on Monday evenings and Saturday

This class will be a blended learning experience using a flipped classroom format- which will require approximately 24 hours in the classroom and reading and homework assignments that must be completed before each class.

Standards of Excellence (SoE) Sub-Committee

The SoE Assessment program is a voluntary self-evaluation process for EMS agencies in Virginia based on eight Areas of Excellence – or areas of critical importance to successful EMS agency management.

Each Area of the Excellence is reviewed using an assessment document that details optimal tasks, procedures, guidelines and best practices necessary to maintain the business of managing an EMS agency.

The sub-committee has 4 agencies (in different parts of the Commonwealth) scheduled for a final pilot of the completed SoE documentation. This process is scheduled to be completed by October 2015 – at which time, changes will be made to the process based on the outcome of the pilots.

The Virginia Recruitment and Retention Network

The Virginia Recruitment and Retention Network last met on November 6, 2014 at the EMS Symposium held in Norfolk. The main discussion centered around the revitalization of the Network by attracting new Network members and being flexible with meeting days and times.

There was also an informative presentation by David Tesh, Recruiter, Chesterfield County Fire and EMS on the use of the SoE program to improve retention of EMS agency members. See **Appendix E.**

When asked about the importance of utilizing the Keeping the Best, EMS Workforce Retention toolkit and the Standards of Excellence program to improve retention of EMS personnel, Dave Tesh stated, "When you look at the history of an emergency services organization, particularly volunteer, the 'glory years' can usually be attributed to a special officer or leader. Using programs like Keeping the Best! And Standards of Excellence can help your organization make every year a 'glory year'. Improving the quality of your organizations leadership should be a primary goal, right up there with service delivery."

The next meeting of the Virginia Recruitment and Retention Network will be held at the Virginia Fire Chief's Conference on Friday February 20, 2015, at 6:00 PM, in Virginia Beach, VA. A motivational presentation will be made by Mr. Mike Pibbs. Mr. Pibbs is a national speaker who will inspire attendees to understand how to sustain organizations through leadership strategies. The mission of the Virginia Recruitment and Retention Network is "to foster an open and unselfish exchange of information and ideas aimed at improving staffing" for volunteer and career fire and EMS agencies and organizations.

Trauma and Critical Care

IX. Trauma and Critical Care

Division of Trauma/Critical Care Staffing

It saddens us to report that Dr. Carol Pugh will be retiring effective April 1, 2015. Carol joined the OEMS on August 10, 2011 and will be retiring to New Hampshire. For those who have worked on projects with Carol, know that she brought unparalleled statistical skills to the OEMS Informatics Coordinator position.

Trauma System

Trauma System Oversight and Management Committee (TSO&MC)

The TSO&MC last met on December 4, 2014, with their new chair, Dr. Michel Aboutanos and their new committee structure. The final agenda and draft minutes to the meeting can be found on-line on the Virginia Regulatory Town Hall.

The committee heard an update on the status of the Virginia Trauma Center Designation Manual which is pending approval from the State Board of Health BOH). The Manual is anticipated to be presented for approval at the March 19, 2015 BOH meeting.

During the December meeting the Committee discussed the three vacant positions on the TSO&MC; citizen/survivor representative, emergency physician, and EMS representative. The EMS position was filled by Mr. Sid Bingley who is a flight nurse for the Carilion Clinic and a captain for Blacksburg Volunteer Rescue Squad. He also brings to the group years of experience as an emergency department nurse at a Level III trauma center.

Dr. Aboutanos has since received nominations for the remaining two positions and will be working to make the final appointments.

The trauma nurse coordinators are undertaking the development of educational materials on trauma triage. The purpose of working on a statewide level to develop trauma triage education is to assure that there is consistent education being given on the regional level. The trauma nurse coordinators have also formed a work group to study issues related to geriatric trauma. Findings of the geriatric work group will be brought to the TSO&MC as needed.

The TSO&MC will also be developing educational materials for trauma center designation site reviewers. The goal of this education is to orient site reviewers to the new criteria in the pending Virginia Trauma Center Designation Manual. Recruitment and education of new site reviewers is also a goal for this effort.

American College of Surgeons (ACS) state site visit

Division of TCC staff continues to work on arranging an ACS State Trauma System Consultative Visit. Currently, the contract rests with the ACS team pending their approval. Work has begun

on data collection for the Pre-review Questionnaire (PRQ) with request for information going out to the regional EMS councils and various sections of the OEMS. Over the next several months many individuals and groups can expect to be asked for assistance in completing the PRQ and in obtaining the needed documents to support the review process. We thank you in advance for your time and attention in compiling a detailed application.

Trauma Designations

During this reporting period several hospitals underwent verification trauma center designation site review. Sentara Virginia Beach General Hospital had a successful site review in October, University of Virginia in November, and Riverside Regional Medical Center in December. Chippenham Medical Center (CMC) increased its level of designation from Level III to Level II after their site visit in early December. CMC had been a Level III trauma center since 1999. The CMC trauma program staffs should be commended for a strong application highlighting their commitment to care of trauma patients.

Trauma Center Fund

Trauma center funds were disbursed in December for the second quarter. These funds are seen in Figure 1. Since 2006 when the trauma fund was instituted, OEMS has distributed over $77 million to the designated trauma centers.

Figure 1 Recent Trauma Center Fund Disbursement

Trauma Center & Level	Percent Distribution	Previous Quarterly Distribution	December 2014	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	14.26%	$550,209.89	$329,806.00	$10,047,516.60
Inova Fairfax Hospital	17.89%	$679,710.57	$393,217.62	$15,222,304.60
Norfolk General Hospital	9.31%	$373,618.05	$327,222.56	$9,414,644.07
UVA Health System	13.13%	$509,897.01	$323,464.83	$10,482,799.55
VCU Health Systems	27.66%	$1,028,256.48	$637,234.95	$18,335010.17
II				
Lynchburg General Hospital	1.88%	$108,551.92	$86,493.24	$1,988,402.19
Mary Washington Hospital	4.38%	$197,739.72	$135,813.39	$1,778,312.78
Riverside Regional Medical Ctr.	3.32%	$159,924.09	$98,001.28	$2,338,598.65
Winchester Medical Ctr.	4.09%	$187,393.93	$121,252.20	$2,977,300.02
III				
New River Valley Medical Ctr.	0.40%	$55,752.74	$34,824.51	$360,008.63
CJW Medical Ctr.	0.95%	$75,374.06	$54,082.85	$890,006.42
Montgomery Regional Hospital	0.17%	$47,547.47	$32,945.64	$353,391.51
Southside Regional Medical	0.62%	$63,601.27	$123,272.85	$620,081.12

Ctr.				
Virginia Beach Gen'l Hospital	1.94%	$110,692.43	$41,635.39	$2,426,351.46
Total		$4,148,269.63	$2,739,267.31	$77,234,727.89

Trauma Performance Improvement Committee (TPIC)

The TPIC also met on December 4, 2014 and discussed the final changes needed to complete the inaugural Trauma Care Performance Improvement Report – please see **Appendix F**. The report is a first step toward providing state regional, and agency level reporting of potential missed-triages of trauma patients. Inter-facility transfer of trauma patients is also being developed. Step 1 of the Statewide Trauma Triage Plan, which are physiologically based, was used to identify patients that should be transferred to designated trauma centers.

Patient Care Information System

Patient Care Information System (VPHIB & VSTR)

Migration to Virginia's Version 3 EMS dataset (VAv3)

"Don't Say You Didn't Know"

During this quarter OEMS has had several opportunities to interact with EMS agencies about the move of VPHIB from its current version 2 standard to the new version 3 national standard. These opportunities included a two-day summit co hosted by OEMS and ImageTrend immediately preceding the EMS Symposium. VPHIB staffs also provided educational sessions throughout symposium, and training webinars began around the same time.

The OEMS/ImageTrend Summit was a two-day meeting where two representatives from each EMS agency which owns its own license for ImageTrend's EMS or EMS/Fire product. The purpose of the summit was to try and provide agencies with guidance on setting up their new version 3 products. It was OEMS and ImageTrend's goal to have these agencies hear the same message from the state and ImageTrend at the same time so agency level implementations can be performed consistently and avoid discovering issues after implementation.

The summit was attended by approximately 80 agency representatives and we believe most if not all attendees thought it was a valuable meeting. ImageTrend staffs provided education on their new product and provided an overview of how they would be implementing the product on the agency level. OEMS staff provided information on the national EMS data standard in an effort to show agencies how they can extend the dataset for local needs without conflicting with the state and national programs.

Agency level issues also came to light during the two-day session. Most importantly those agencies that also collect and report fire service data expressed serious concerns about the status of fire service data collection software. Specifically, the version 3 national EMS data standard is so significantly different that it has required most of the time and attention of software vendors that provide both products.

Obviously, for those agencies that have dual reporting requirements they have a need to have both EMS and fire data collection programs to move together in a synchronized fashion. Currently, many agencies have computer aided dispatch (CAD) interfaces that connect to a single reporting system that collects fire and EMS data, performs billing, scheduling etc. While OEMS does not collect fire related data we are sensitive to causing agencies to lose the ability of its staff to complete one record used for EMS and fire, to lose or have to pay for more than one CAD interface, and interrupt other workflow processes. Additionally, not being able to implement a new EMS and fire product together means they will have to perform full agency training twice.

Because of this OEMS has decided to widen the window of implementation. OEMS' goal was to limit the implementation window to a six-month period in an effort to minimize the amount of downtime for data output/reporting. Giving the complexities of version 3 and the advances in fire and EMS reporting that have married these processes to a single point of collection; this goal has to be set aside.

In return, we ask the EMS system to understand OEMS' ability to produce data output will become increasing hampered during the widened implementation window. Also, our ability to meet the current v2 data submission deadlines set by NEMSIS will not able to be met. There will be a period of time that Virginia will have decreased submissions to the NEMSIS national

EMS database. Figure 2 below shows the NEMSIS timeline. Version 2 data collection will cease at the end of 2015.

Figure 2 NEMSIS Version 2 Closeout

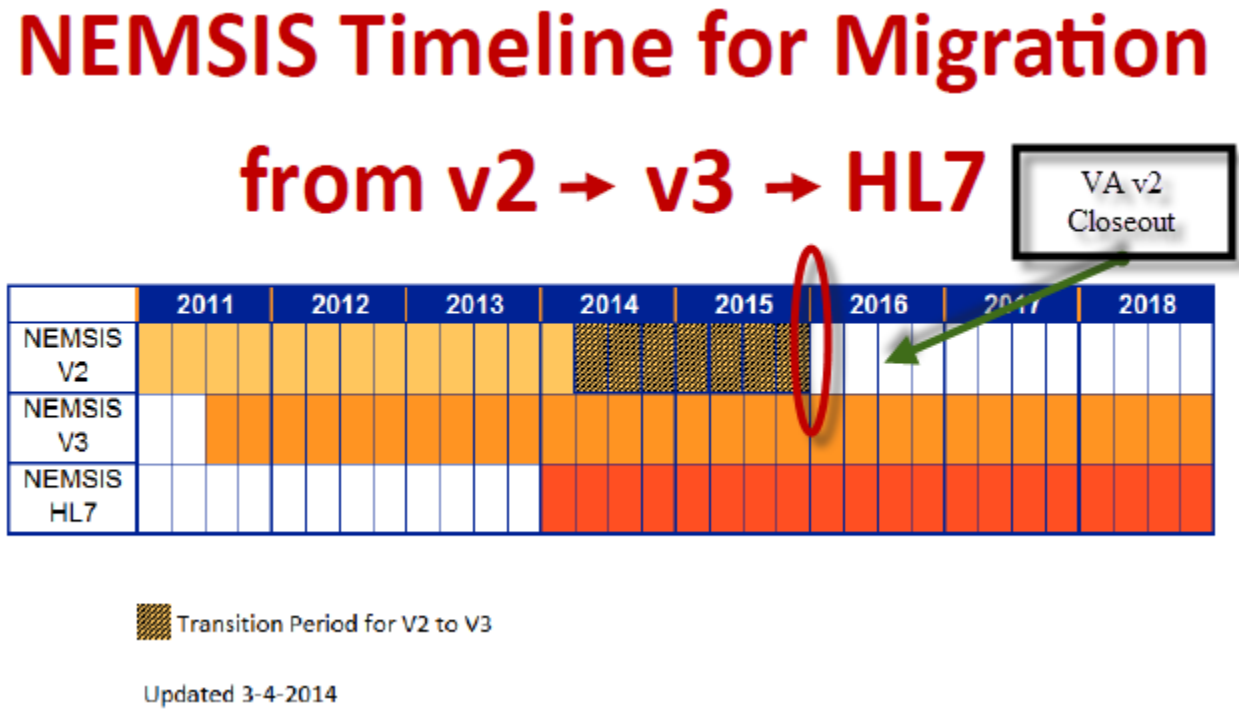


Figure 3 below shows the revised VAv3 implementation timeline. First, it is important to know that any agency/vendor may implement earlier than shown on the timeline below. VAv3 is ready for use now. As shown below, OEMS will begin by requiring agencies that use the OEMS provided ePCR (Field Bridge) to move to the version 3 product beginning in July.

Agencies using the State's ePCR that do not bill for service will be implemented on July 1st, 2015. On August 31, 2015 EMS agencies that use the state ePCR and do not bill for their services will have their version 2 accounts closed.

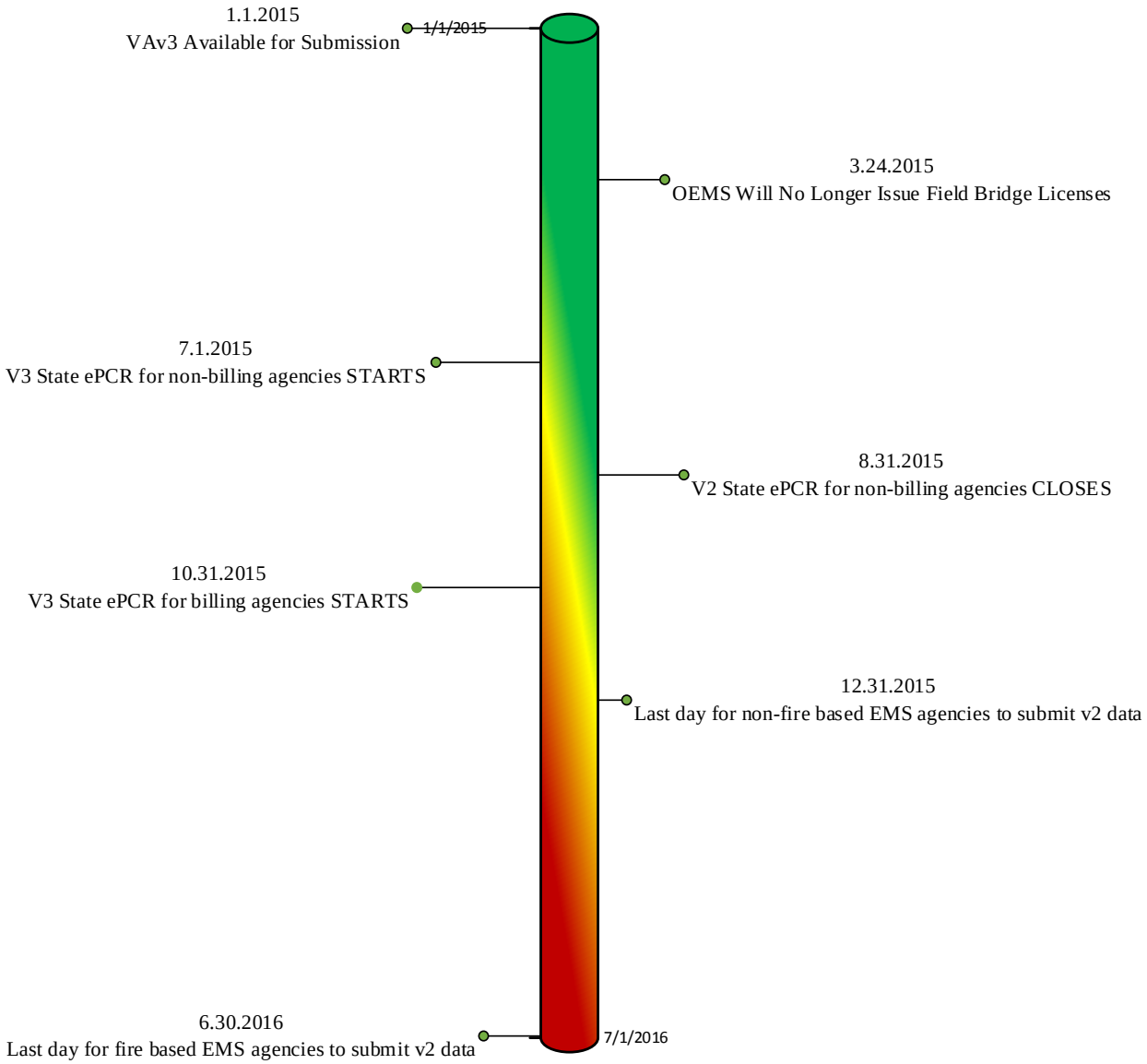
Agencies that perform direct entry of EMS data from paper run forms directly into the VPHIB website will need to move to VAv3 by August 31, 2015.

Agencies using the State's ePCR and bill for service will be implemented on September 1st, agencies that bill for service and utilize the State provided ePCR will have their version 2 accounts closed on October 31, 2015.

December 31, 2015 will be the last day agencies that utilize their own ePCR (i.e. ImageTrend, Zoll, emsCharts and so on). Again, these agencies can move to VAv3 anytime prior to December 31st.

Agencies that also provide fire services will need to transition to VAv3 no later than June 30, 2016. This does not include EMS/fire services that use the State provided ePCR. This extension was felt necessary due to the technical issues that are arising for agencies that use a single product to report both EMS and fire incidents.

Figure 3 Version 3 Implementation Timeline



Virginia Statewide Trauma Registry (VSTR)

The VSTR application is now one year old. The VSTR has been functioning well with little to no technical issues. There have been some minor compatibility issues limited to a single third party trauma registry software vendor that are occurring on the vendor side. This vendor affects two hospitals. Staff continues to meet technical challenges getting a direct connection to the database where the trauma data is stored. This has been an ongoing issue since July 2014. Until this connection can be established we are unable to provide data quality feedback to the hospitals. We continue to work with VITA/NG (the state's IT program) to resolve what should be a minor issue.

Other VPHIB and VSTR Activities

Data Requests

- Provided a report containing VPHIB data on duration of stroke symptoms and transport times for CY 2011-2013 for Dr. Jack Cote and the TJEMS Quarterly Stroke PI Meeting.
- Summarized 911 call validity data by month for 2011- 2013 at the agency, region, and state levels for Shawn Hite of Regional EMS of Pulaski County.
- Created a benchmarking report for Robert Davis of the Virginia Beach Department of Emergency Medical Services using CY 2012-2013 VPHIB data on counts of EMS system response time in minutes to cardiac arrest calls.
- Prepared an *ad hoc* report on anaphylaxis-associated EMS calls in Virginia during FY 2014 for Gary Brown.
- Provided an audit report to Bee Betts on ALS procedures performed by Southside Virginia Emergency Crew staff during October 2013 through October 2014.
- Responded to a request from Mohamed Abbamin, Policy Manager in the Virginia Department of Fire Programs for summary data for the EMS agencies in Giles County. The information is to be used by the Virginia Fire Services Board and Virginia Department of Fire Programs as part of a Fire and EMS Study for the county.
- Created a report using 2013 VSTR Data for patients 65 years of age and older having a ground level fall for Nancy Malhotra on behalf of the Trauma Program Managers; presented the information to the group at their December quarterly meeting.
- Provided Kelley Rumsey of the Children's Hospital of Richmond at VCU with 2013 pediatric trauma statistics (from VSTR) for use in her educational session at the Annual EMS Symposium.
- Developed a HIPAA compliant patient level data file for Dr. Jim Jeng, Chair, Disaster Subcommittee of the American Burn Association. The data are to be used to determine the need for a new American Burn Association verified burn center to service the population in the Northern Virginia suburbs of Washington DC. I included data for the whole state and asked that they look for other areas in need of this type of support.
- Provided a HIPAA compliant patient level dataset for Jackson Deziel of the University of North Carolina – Charlotte for use in his PhD dissertation.

- Developed a HIPAA compliant patient level dataset for Cathy Cockrell to use in a graduate level research project focusing on the impact of CPR methodology (chest compressions versus mechanical CPR) on the survivability of patients that arrest en route to the hospital.
- Developed a HIPAA compliant patient level dataset for use by the Department of Industrial and Systems Engineering at Virginia Tech. They are studying the potential effects of implementing EMD in Montgomery County and needed time measurement data for all of the EMS agencies in the county to construct a simulation model. The results of the model will be shared with the New River Valley Emergency Communications Authority.
- Responded to a media data request via Marian Hunter (OEMS Public Relations Coordinator) on Medevac/HEMS use by EMS region for 2011-2013.

OEMS Annual Symposium

- VPHIB Staffs hosted a two day pre-Symposium VPHIB version 3 summit, presented in conjunction with ImageTrend (vendor for the VPHIB version 3 software)
- VAv3 administrator and VAv3 ePCR training were provided throughout classtimes on Friday and Saturday of symposium.
- The Informatics Coordinator provided three presentations (twice each) during the Annual Symposium:
  - *Basic Reporting Using State Bridge (VPHIB)*
  - *Intermediate/Advanced Reporting Using State Bridge (VPHIB)*
  - *Lies, Damned Lies, and Statistics*

VAv3 Training and Implementation Activities

- Selected 10 agencies to serve as a beta test group for the new data reporting system (VAv3) based on specific criteria:
  - Agencies that had quality scores of 97% or better.
  - Selected agencies with median run volumes between 250 and 1200 per year.
  - Developed form for beta agencies to use when reporting issues.
- Prepared training materials (handouts and PowerPoint presentations) for beta training classes.
- Conducted online training classes via webinar for agencies covering the administrative functionality and the Electronic Patient Care Report (ePCR) use (4 sessions per week).
  - Reviewed software applications each Monday for any changes which are incorporated into upcoming training classes.
- Began working on instructional videos to be used by agencies for training.
  - Staff became educated on new recording software package.
  - Developed scripts for dialogue.
  - Created video segments and then matched them to the audio segments.

- Created different versions of the output for multiple platform delivery (PC, Smartphone, etc).
- Ensured that videos could be easily modified as enhancements and improvements are made to VAv3.

- Worked on quality testing of the new application
  - Uncovered over 75 issues that were reported to the software vendor
    - Discovered several security related problems that the vendor corrected prior to release.
  - Documented specific details on all issues including steps to reproduce so that problems could be retested once software corrections had been made.

Emergency Medical Services for Children (EMSC)

EMSC Committee Update

The EMS for Children Committee of the State EMS Advisory Board met January 8, 2015 at the Virginia OEMS offices.

- Members received an update from Chair Samuel Bartle, MD concerning the discussion of proposed pediatric trauma center criteria by the EMS Advisory Board at their November 2014 meeting, and the eventual action related to the EMSC Committee's request for "clarification" of the criteria. The next likely step for the pediatric trauma center criteria will be consideration as part of a larger trauma designation manual revision by the Board of Health at their March 20 meeting.
- The special topic for the January 8th meeting was "pediatric medication errors", and the Committee received an excellent presentation from Tammy Nguyen, PharmD, from Virginia Commonwealth University's Emergency Medicine Department. There was extensive discussion concerning the topic and potential interventions to aid in decreasing these kinds of medical errors, and Dr. Nguyen was urged to propose this topic for presentation at annual EMS Symposium.
- The Committee was updated on current proposed legislation, EMSC State Partnership Grant details, member organization, and committee reports were taken, and meeting dates for the rest of the year were discussed and confirmed. The next meeting of the EMSC Committee is set for April 9, 2015 at 3:00 pm in the OEMS offices in Glen Allen, Virginia.

Hospital and EMS Agency Sections Coming to EMSC Website

The EMS for Children website (within the Office of EMS website) will be undergoing revisions, and there will specific sections established for hospitals and EMS agencies.

- The hospital section will contain resources and toolkits developed as a direct result of data received during the Pediatric Readiness Assessment. More than 4,000 hospitals nationally participated in this assessment. Major topics will likely be the development of inter-facility

transfer guidelines and agreements, pediatric quality improvement, and pediatric disaster planning and preparedness.
- The EMS agency section will contain resources and toolkits developed in part as a result of the national EMS assessment completed last year by more than 80% of EMS agencies that respond to 911 calls and transport children.

Development of Quality Improvement Indicators

The Virginia EMS for Children program is developing sample QI markers/indicators for hospital emergency departments as a resource for evaluating and improving care. An example of areas covered might include these topics:

- Asthma
- Child maltreatment
- Diabetic ketoacidosis
- Hematology/oncology
- Head trauma
- Length of ED stay
- Pain control
- Recording/ use of vital signs
- Mock codes
- Moderate sedation

Potential QI indicators for EMS agencies seeking to evaluate and improve prehospital field care are also being developed, and at least some of these will be based upon data available though the Virginia PreHospital Information Bridge (VPHIB). Quality improvement indicators are just one example of the kinds of items that will be available in both of the new sections planned for the EMSC website.

NASEMSO Pediatric Emergency Care Council (PECC) Update

The PEC Council is a standing council of the National Association of State EMS Officials (NASEMSO), and works at a national level to facilitate improvement in pediatric emergency care, especially by working with federal partners within the umbrella of the Health Resources and Services Administration (HRSA), the Department of Transportation (DOT, and Homeland Security. The Virginia EMSC Coordinator just finished a term as Chair of this council, and will continue to serve in a leadership position as “Immediate Past-Chair” for another two years.

EMS Education Toolkit for Pediatrics

Over the past several months, members of a special working group have collaborated to compile education resources to assist in the education and relicensure of practitioners related to pediatrics. The EMS Education Toolkit for Pediatrics is the result of a collaborative effort of the National Association of State EMS Officials (NASEMSO), the American Academy of Pediatrics (AAP), the EMSC National Resource Center (NRC), National EMSC Data Analysis Resource Center (NEDARC), the National Association of EMS Educators (NAEMSE), and the National Association of EMTs (NAEMT) with support from our federal partners at the National Highway

Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration EMS for Children Program (HRSA).

The toolkit is intended as a resource that can be used to inform the state EMS license renewal process to improve evaluation and performance related to pediatric skills competency although EMS Educators, EMS agencies, EMS practitioners, and others seeking information to improve pediatric education in emergency medical services will also find the information useful.

The toolkit is available at http://www.nasemso.org/EMS-Education-Toolkit-Pediatrics/.

Next Steps for Pediatric Facility Recognition

The work group which has been addressing a potential pediatric facility recognition program in Virginia is ready to work with stakeholders to determine the most effective "next steps" in moving toward recognizing and encouraging excellence in pediatric emergency care. The group will update the EMSC Committee on a regular basis as to their progress.

On-Site Pediatric Training

EMS agencies interested in on-site pediatric training should contact David Edwards at 804-888-9144 (david.edwards@vdh.virginia.gov) or Dr. Robin Foster (rlfoster@hsc.vcu.edu).

The Virginia EMSC program continues to facilitate access to pediatric education and training, especially in the form of EPC (*Emergency Pediatric Care*), *Emergency Nursing Pediatric Course* (ENPC), and PEPP (Pediatric Education for Prehospital Professionals) courses around the Commonwealth, particularly in areas with historically difficult access to pediatric training.

On-Going Purchasing Highlights (with HRSA State Partnership Grant funding):

- ***iSimulate System for pediatric training*:** The purchasing process is almost complete for an i-Pad based advanced simulation system for pediatric scenario training. The interactive system will allow for scenario stations to be fully operational without the use of actual monitor/ defibrillators and their inherent safety issues, logistical and connectivity problems. This will simplify the effort and ability of educators and trainers to provide quality technical stations for courses like PALS, PEPP, EPC, APLS, etc.—especially at the Annual EMS Symposium, but elsewhere as is reasonable.
- ***Pediatric training manikins:*** Appropriate use child and infant manikins are being purchased for use with the ISimulate System and for other training opportunities.
- ***Broselow™ Pediatric Emergency Tapes***: An additional order of 1,850 length-based pediatric emergency tapes is being placed to complete the re-supply of updated tapes for Virginia transport ambulances.
- ***Child immobilization devices*:** The EMSC program is in the process of purchasing approximately 160 devices to aid in the immobilization of injured children. 125 of these devices have been pre-assigned to requesting agencies, and we hope to have the order finalized in the near future if the purchase receives final state approval. Many of these items will be delivered in person to agencies by the EMSC Coordinator and provide an

opportunity for additional evaluation of agency pediatric needs and recruiting of pediatric agency liaisons.

- ***Educational Support Materials:*** Textbooks, manuals, miscellaneous course fees, instructor support and other items are being provided to facilitate access to pediatric education and training in Virginia.

EMSC State Partnership Grant Notes:

- The first manuscript generated directly from the Pediatric Readiness Assessment of hospitals was accepted by JAMA Peds (publication date unknown). Many will follow.
- With the last two major EMSC assessments (hospital *and* EMS agency) now complete, the federal EMSC program is reviewing and evaluating the current EMSC performance measures. State EMS for Children grantees expect to be presented with a new set of Performance Measures in early 2016 (not that far away) that will guide state EMS for Children programs going forward.
- In place of the Annual EMSC Program Meeting this year there will be four Regional Symposia that EMSC Program Managers (and FAN representatives if they can) will be required to attend. EMS for Children Symposia #4 will include Virginia and is scheduled for August 11-13 in Philadelphia.
- We are awaiting word on funding for Virginia's March 2015-April 2016 EMSC grant cycle. It seems very likely that the amount of $130,000 previously approved for this period will not change (as a result the recent continuing resolution passed by Congress to fund the government through the end of 2016), but nothing is final at this point.
- May 20, 2015 has been declared "EMS for Children Day"

On-Site ED Pediatric Assessments: No-cost collaborative assessments of hospital emergency department pediatric needs and capabilities are available through the EMS for Children program (within the Division of Trauma and Critical Care of the Office of EMS).

Program staff currently use the consensus document "Joint Policy Statement - Guidelines for Care of Children in the Emergency Department", American Academy of Pediatrics, October 2009 as a guide to assess gaps in basic ED preparedness. This document delineates "guidelines and the resources necessary to prepare hospital emergency departments (EDs) to service pediatric patients", and is endorsed by many national professional organizations. Hospital ED leaders who may have an interest in this are urged to contact David Edwards by email at david.edwards@vdh.virginia.gov or by direct phone at (804) 888-9144.

Suggestions/Questions

Suggestions or questions regarding the Virginia EMS for Children program should be submitted to David Edwards via email at david.edwards@vdh.virginia.gov, or by calling the EMSC program within the Office of EMS at 804-888-9144 (direct line).

Durable Do Not Resuscitate (DDNR)

We continue to support the DDNR program. There are no significant events to report this quarter.

Respectfully

Submitted

OEMS Staff

Appendix

A

2015 Office of EMS Legislative Grid
January 30, 2015

Bills	Committee	Last action	Date
HB 1344 - Rasoul - Flashing lights on motor vehicles; "move over" law.	(H) Committee on Transportation (S) Committee on Transportation	(S) Referred to Committee on Transportation	01/27/15
HB 1391 - Albo - Interstate Health Care Compact; established.	(H) Committee on Rules	(H) Referred to Committee on Rules	12/15/14
HB 1392 - Garrett - Emergency contact program; DMV may establish.	(H) Committee on Transportation (S) Committee on Transportation	(S) Referred to Committee on Transportation	01/27/15
HB 1413 - Filler-Corn - Hospital discharge procedures; designation of individual to receive information and instructions.	(H) Committee on Health, Welfare and Institutions	(H) Committee substitute printed 15103966D-H1	01/29/15
HB 1432 - Cole - Health care providers; regulation, prohibited acts, Class 1 misdemeanor.	(H) Committee for Courts of Justice	(H) Subcommittee recommends laying on the table	01/14/15
HB 1441 - Bell, Richard P. - Child abuse or neglect, suspected; person required to report, training program required.	(H) Committee on Health, Welfare and Institutions	(H) Assigned HWI sub: Subcommittee #3	01/16/15
HB 1458 - O'Bannon - Naloxone; administration in cases of opiate overdose.	(H) Committee on Health, Welfare and Institutions	(H) Committee substitute printed 15103589D-H1	01/29/15
HB 1500 - Carr - Overdoses; definition, safe reporting by individual.	(H) Committee for Courts of Justice	(H) Assigned Courts sub: Criminal Law	01/13/15
HB 1544 - Fariss - Emergency vehicles; vehicle illuminated identification systems.	(H) Committee on Transportation	(S) Referred to Committee on Transportation	01/27/15

	(S) Committee on Transportation		
HB 1552 - Filler-Corn - Child welfare agencies; regulation, national criminal history record check requirement.	(H) Committee on Health, Welfare and Institutions	(H) Assigned HWI sub: Subcommittee #3	01/16/15
HB 1553 - Marshall, D.W. - Emergency notifications, local; any locality may by ordinance.	(H) Committee on Counties, Cities and Towns (S) Committee on Local Government	(S) Referred to Committee on Local Government	01/29/15
HB 1558 - Rust - Adult fatality review teams, local and regional; created, penalty.	(H) Committee on Health, Welfare and Institutions (S) Committee on Education and Health	(S) Referred to Committee on Education and Health	01/28/15
HB 1568 - Orrock - Emergency vehicles; bridge weight limits.	(H) Committee on Transportation	(H) Assigned Transportation sub: Subcommittee #1	01/16/15
HB 1579 - Cole - Vehicle registrations; expiration and renewal on or after July 1, 2015.	(H) Committee on Transportation	(H) Tabled in Transportation	01/27/15
HB 1584 - Stolle - Fire services and emergency medical services; revises certain terminology.	(H) Committee on Health, Welfare and Institutions (S) Committee on Education and Health	(S) Referred to Committee on Education and Health	01/28/15
HB 1611 - Miller - Assault and battery; felony when committed against certain persons.	(H) Committee for Courts of Justice	(H) Reported from Courts of Justice with amendments (21-Y 0-N)	01/28/15
HB 1633 - Gilbert - Virginia Freedom of Information Act; record exemption for certain health records.	(H) Committee on General Laws	(H) Read first time	01/29/15
HB 1657 - Rust - Advance	(H) Committee for	(H) Reported from	01/28/15

directives; directions about life-prolonging procedures during pregnancy.	Courts of Justice	Courts of Justice (21-Y 0-N)	
HB 1660 - Rust - Recognition of EMS Personnel Licensure Interstate Compact.	(H) Committee on Health, Welfare and Institutions	(H) Subcommittee recommends laying on the table	01/22/15
HB 1732 - Hodges - Naloxone or other opioid antagonists; dispensing and administration.	(H) Committee for Courts of Justice	(H) Assigned Courts sub: Civil Law	01/20/15
HB 1745 - Lingamfelter - Fire Programs Fund; expense of administration of insurance laws and regulatory revenue taxes.	(H) Committee on Commerce and Labor	(H) Referred to Committee on Commerce and Labor	01/12/15
HB 1833 - Gilbert - Naloxone; administration by law-enforcement officers.	(H) Committee for Courts of Justice	(H) Assigned Courts sub: Civil Law	01/20/15
HJ 501 - Landes - Study; JLARC; reorganization of law-enforcement agencies; report.	(H) Committee on Rules	(H) Subcommittee recommends laying on the table	01/22/15
HJ 571 - Hugo - Commending the Fairfax County Fill the Boot Campaign.		(S) Agreed to by Senate by voice vote	01/29/15
HJ 694 - Campbell - Commending the Max Meadows Volunteer Fire Department.		(S) Agreed to by Senate by voice vote	01/29/15
SB 692 - Deeds - Virginia Law Officers' Retirement System; conservation officers.	(S) Committee on Finance	(S) Read third time and passed Senate (38-Y 0-N)	01/30/15
SB 754 - Carrico - Vehicle registration; increases fees, allocates funds for Department of State Police.	(S) Committee on Finance	(S) Rereferred to Finance	01/21/15
SB 837 - Puller - Emergency medical services personnel; alternate method created for background checks.	(S) Committee on Education and Health	(S) Referred to Committee on Education and Health	01/05/15
SB 845 - Stanley - Volunteer first responders; immunity from civil liability when in	(H) Committee for Courts of Justice	(H) Referred to Committee for Courts of Justice	01/30/15

route to an emergency.	(S) Committee for Courts of Justice		
SB 877 - Cosgrove - Recognition of EMS Personnel Licensure Interstate Compact; created.	(S) Committee on Education and Health	(S) Rereferred to Education and Health	01/20/15
SB 892 - Petersen - Overdoses; establishes an affirmative defense to prosecution of an individual, etc., safe reporting.	(S) Committee for Courts of Justice	(S) Read third time and passed Senate (39-Y 0-N)	01/29/15
SB 938 - Stuart - Fire services and emergency medical services.	(H) Committee on Health, Welfare and Institutions (S) Committee on Education and Health	(H) Referred to Committee on Health, Welfare and Institutions	01/30/15
SB 997 - Stuart - Emergency medical services personnel; background checks, process.	(S) Committee on Education and Health	(S) Referred to Committee on Education and Health	01/12/15
SB 1167 - Hanger - Epinephrine auto-injectors; possession and administration by certain individuals.	(S) Committee on Education and Health	(S) Assigned Education sub: Health Professions	01/20/15
SB 1186 - Obenshain - Naloxone; administration in cases of opiate overdose.	(S) Committee on Education and Health	(S) Assigned Education sub: Health Professions	01/20/15
SJ 259 - Vogel - Confirming Governor's interim appointments of certain persons.	(S) Committee on Privileges and Elections	(S) Recommitted to Privileges and Elections	01/23/15
SJ 260 - Vogel - Confirming Governor's interim appointments of certain persons.	(S) Committee on Privileges and Elections	(S) Recommitted to Privileges and Elections	01/23/15
SR 77 - Miller - Commending Riverside Hospital.		(S) Agreed to by Senate by voice vote	01/29/15

Appendix

B

THIRD QUARTER 2014

EMS Patient Safety Event Report

E.V.E.N.T.
EMS Voluntary Event Notification Tool
An EMS Culture of Safety Initiative

Welcome!

Welcome to the EMS Voluntary Event Notification Tool (E.V.E.N.T.)!

This is an aggregate report of the patient safety events reported to E.V.E.N.T. in the third quarter of 2014. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected will be used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool. The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

"… patient was able to wriggle out of restraints multiple times and each time became combative, attempting to harm providers… Patient made multiple threats to providers stating she intended to kill them …." – 3Q2014 EVENT Provider Violence Report #3

This is the aggregate Patient Safety E.V.E.N.T. summary report for third quarter 2014.

PROVIDED BY:

The Center for Leadership, Innovation, and Research in EMS (CLIR)

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada
Chefs Paramédics du Canada

NATIONAL EMS MANAGEMENT ASSOCIATION

NAEMT

NASEMSO

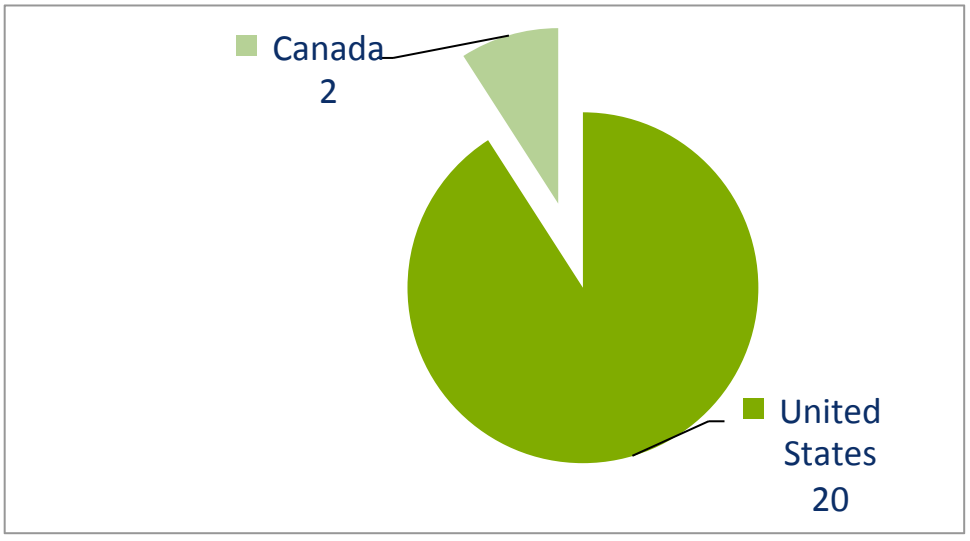
Patient Safety Event Reports Sorted Quarterly

	2012	2013	2014
Jan - Mar	6	31	30
Apr - Jun	9	39	29
Jul - Sep	13	35	22
Oct - Dec	6	32	
Total	34	136	81

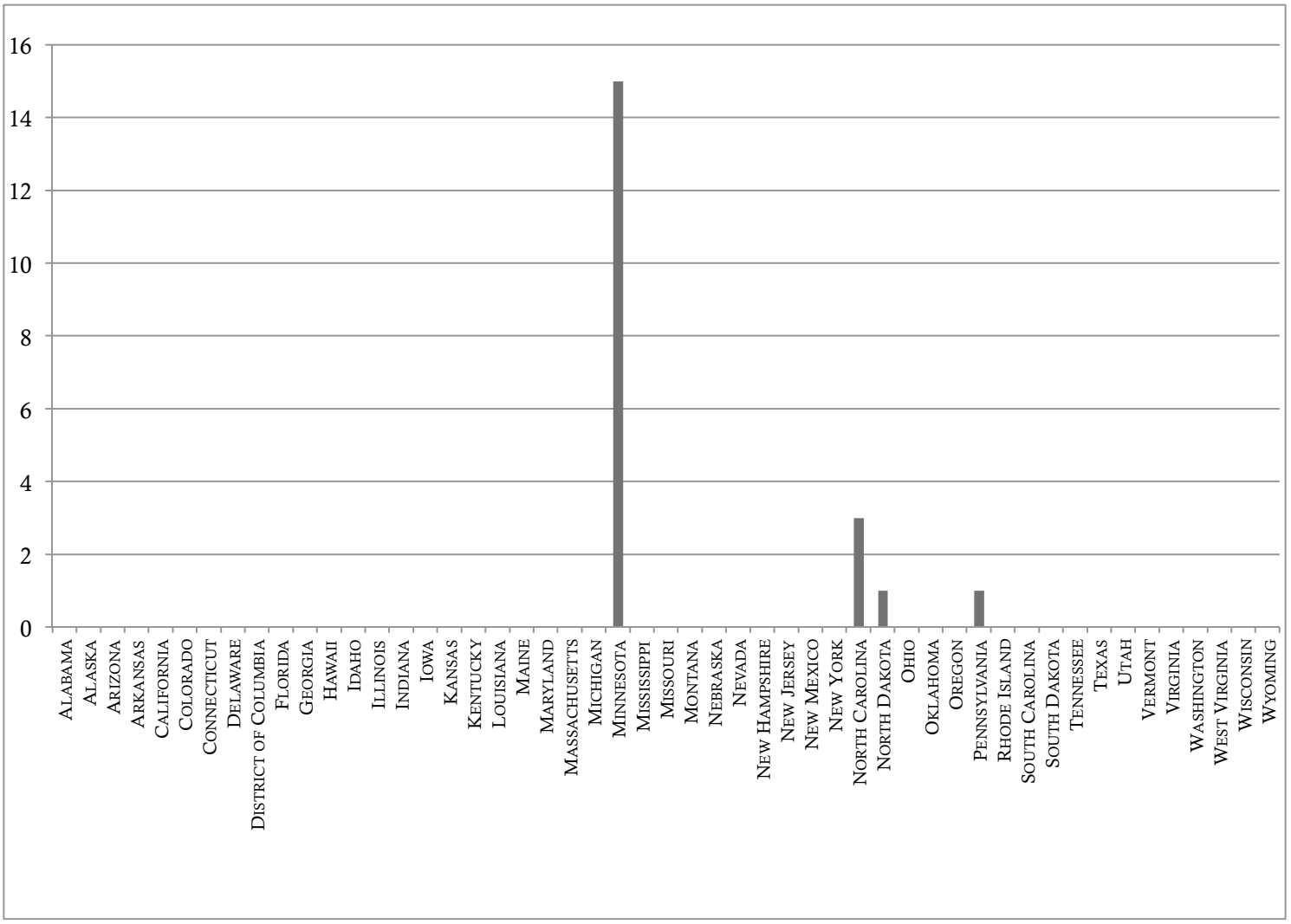
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

When an anonymous EVENT report is submitted, our team is notified by email. In the United States, the anonymous patient safety event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

Quarterly Patient Safety Events by Country



Patient Safety Events Reported by State (United States of America)



Many of our reports this quarter have been generated from Minnesota. Thanks to the Minnesota agencies and practitioners for supporting this body of knowledge! North Carolina, North Dakota and Pennsylvania were also great contributors this quarter. If your EMS agency has an internal reporting system for patient safety events, we encourage you to have your staff member that receives those reports to also enter them into our anonymous system.


Alabama Emergency Medical Technicians Association


NAEMSP


CAAHEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAEMED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE


NAEMT


National Registry of Emergency Medical Technicians
THE NATION'S EMS CERTIFICATION


NATIONAL
EMS
MANAGEMENT
ASSOCIATION


National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE ASSOCIATION INC.
NEW YORK STATE


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION

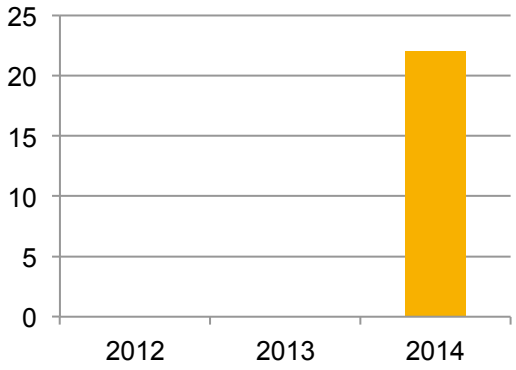

VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

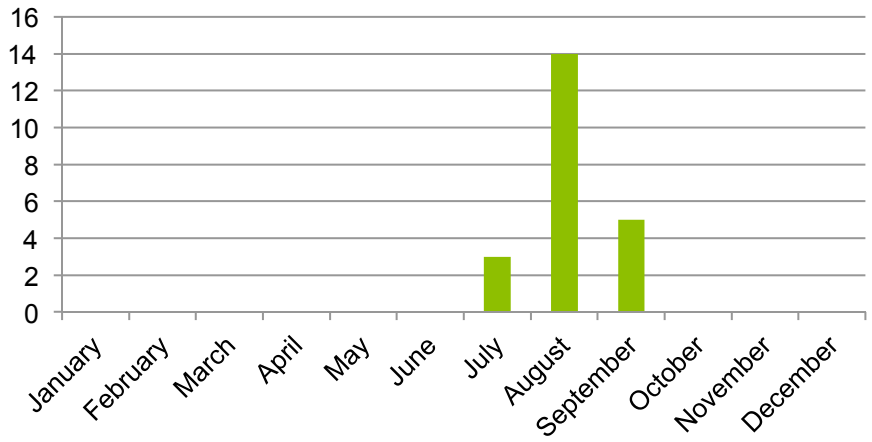

AAMS


THE UNIVERSITY OF ARIZONA
MEL AND ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

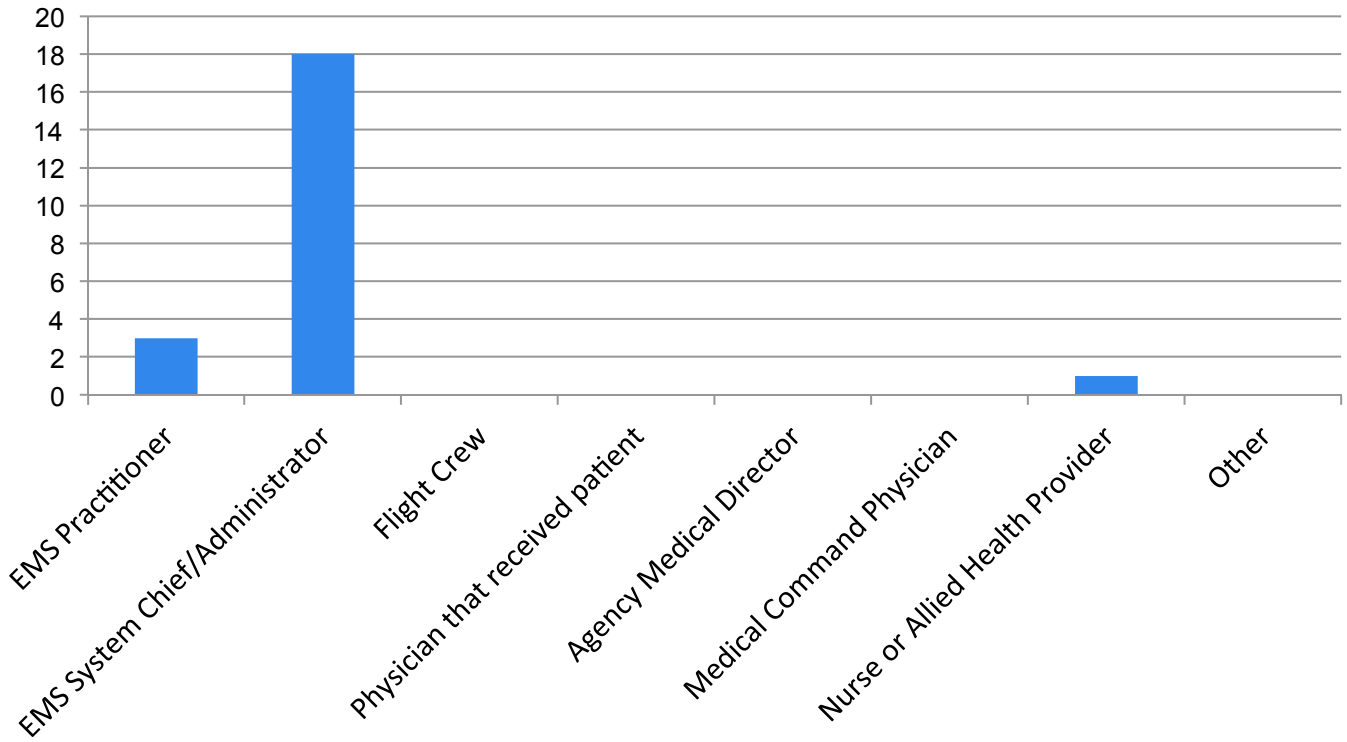
Year Reported Patient Safety Event Occurred



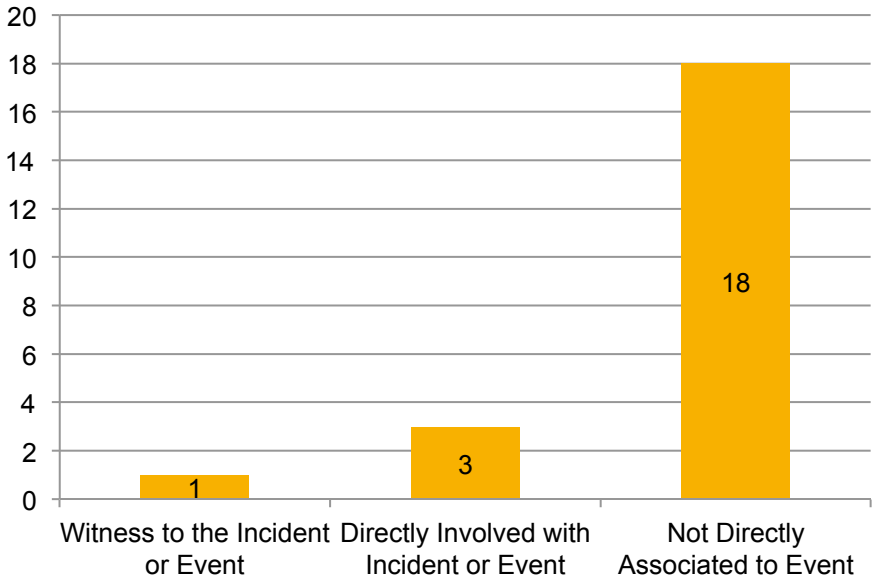
Month of Reported Patient Safety Event



Role of Person Reporting Incident

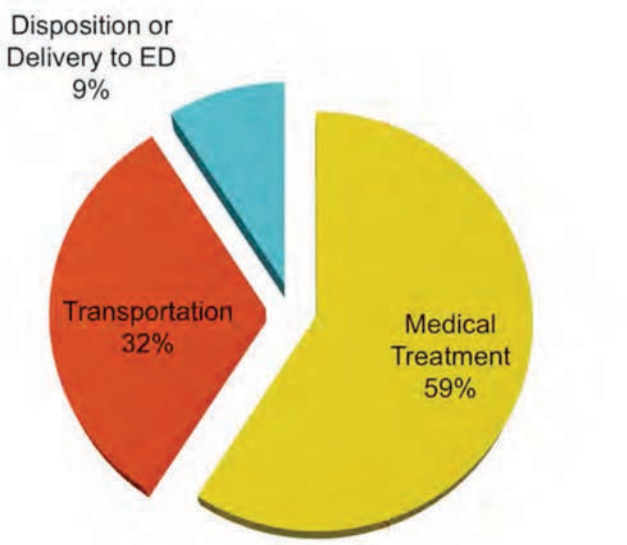


Involvement in Safety Event

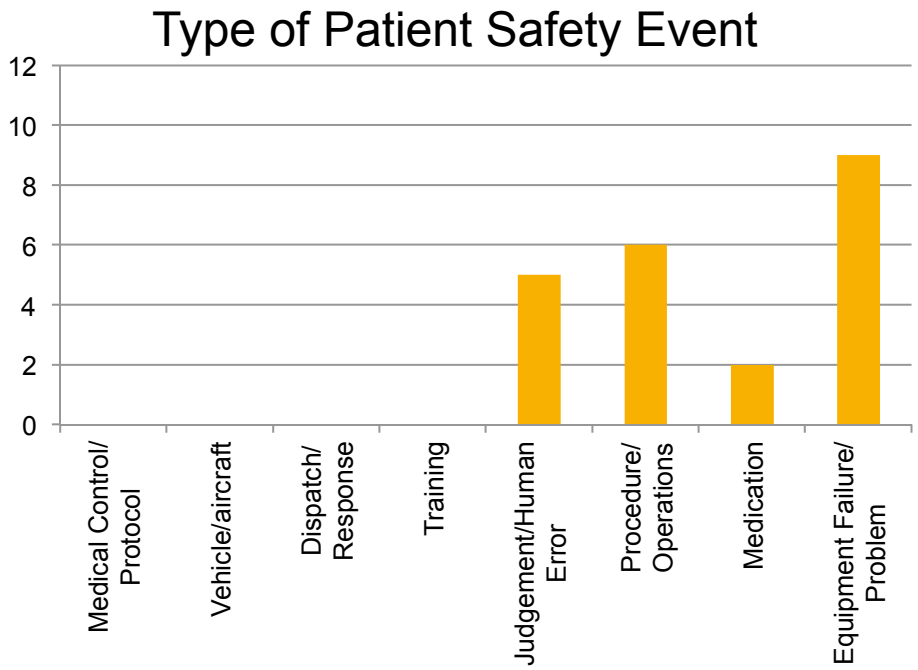


The reporters from this period are generally “not directly associated to the event”. The EMS system administrator dominates the “not directly associated” group.

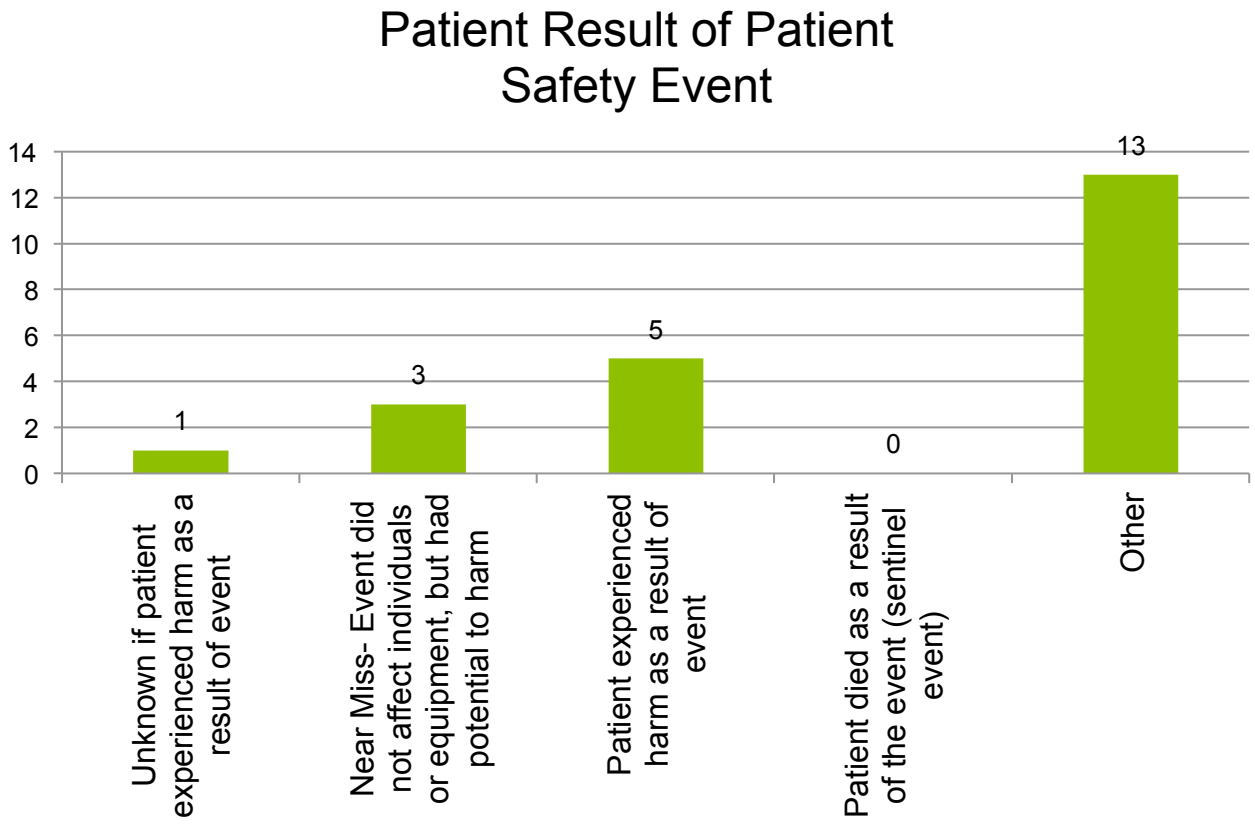
Category of Event



The vast majority of the events reported this period occurred in the medical treatment phase. Transportation is the second most reported.



Equipment failures dominated the type of event, followed closely by medication event. Clinical judgment or human error, medical control, vehicle and procedure events were also reported.



#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
1	With the ambulance parked in the hospital garage, the crewmember attending dropped the laptop computer about 3 inches, which hit the stretcher patient on the head causing a small area of contusion and tenderness. The injury was very minor and was treated with an ice pack. The crew was moving the laptop to obtain a patient consent signature. An apology was provided the patient and no hematoma or laceration resulted. The mishap was reported to the receiving hospital staff. The pt. was being transported for abdominal pain & SOB related to a possible alcohol overdose.	Human error related to dropping the laptop. Avoid the risk by not passing equipment over the patient's head.
2	While unloading a patient on a [manufacturer/model] powered stretcher, the center safety catch bar did not engage the floor hook. The hook went through the 2-1/2 inch space between the bar end and the small loading wheel. The weight of the stretcher and the patient suddenly shifted to the foot-end operator as the middle set of loading wheels came off the ambulance floor. The control end operator had to support the foot-end weight a little longer while both sets of legs were then lowered. No harm to the patient. The control end operator reported the concern and made recommendations for how to avoid this issue during removal. A 1st report of injury was filed for foot-end operator related to back strain.	The design of the middle position safety catch bar allows the floor hook to pass between the wheel and the bar. It is difficult for the assistant operator during removal to visualize the position of the floor hook in relation to that catch bar. The red indicator light, designed to help identify a stop point, is difficult to see in daylight. The manufacturer should redesign the catch bar to eliminate the 2-1/2 inch space on both sides, which creates the potential for this event type.
3	Upon the arrival to the scene of a cardiac arrest the paramedic crew experienced a malfunction of their defibrillator/monitor. The device would not power up to provide rhythm analysis and/or clinical therapy.	Manufacturer device malfunction Unknown at this time
4	Due to the structure of the residence, the stretcher could not make it to the back room where the patient was located. Patient was placed in a computer chair with wheels that sat low to the floor. Medical responder was pulling patient legs to maneuver to the hall way and I was pushing the back of the chair and holding patient up. Once we got to the door opening, the chair stopped rolling but the medical responder was still pulling the patient legs. As a result the patient weight shifted forward, causing the chair to become off balance and the chair tilted forward. I grabbed the patient and pulled him back with one arm, so he wouldn't fall face forward. The momentum caused me to fall as well. Patient landed on his buttocks and then upper body followed. I landed beside the patient. Neither the patient nor myself was hurt.	Patient wasn't securely strapped down to the chair. Always use a stair chair with straps.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
5	During transport, ETOH intoxicated patient, with minor nosebleed injury from MVC where he was the driver, realized that he would be arrested after arrival at hospital. Pt. removed stretcher straps & moved off stretcher to exit side door of ambulance. Vehicle was stopped at an intersection. Attending medic briefly tried to retain pt. & keep him from falling out of door when pt. made a threatening gesture with his fist after he exited thru side door. After a short chase was quickly recaptured by police closely following the ambulance. Pt. ultimately transported to hospital in police squad. Crew followed police to hospital after patient's elopement from ambulance.	This was a patient refusal to be transported decision not influenced by the crew's actions in any way. Law enforcement riding with in ambulance may have deterred the elopement.
6	[While unloading patient at hospital, the stretcher catch bar did not engage the floor hook and loading wheels dropped off the floor landing on the step bumper. The vehicle was parked on an uphill slope which was a contributing factor. The crew kept the foot-end of the stretcher low to keep the patient level, the patient weighed 280 lbs. & was in leg chains and shackles during a transport from a prison. Resulted in no injury to patient and minor neck and shoulder strain for the assistant operator.	The foot-end stretcher operator did not follow proper removal procedures, most importantly, not waiting for the assistant to be in position and not stopping to allow the assistant to check the safety bar position before pulling the loading wheels off the ambulance floor. The ambulance being parked on a slope and the patient's weight combined with gravity also caused the operator to come back too fast and out of control. Prevention of this type event involves parking the ambulance on level ground whenever possible and always pausing during removal to see if the catch bar will engage the floor hook.
7	During transport, an ETOH intoxicated patient, with minor nosebleed injury from a MVC where he was the driver, realized that he would be arrested for DUI after arrival at the hospital. This patient quickly removed the stretcher straps and moved off stretcher to exit out the side door. The vehicle was stopped at a busy intersection. The attending medic tried to distract and reason with the pt. and briefly grabbed a hold of his shirt to keep him from falling out of the door. The pt. then raised one arm and made a threatening gesture with his closed fist to indicate 'don't try and stop me' after he exited thru the side door. After a short 2-block chase, he was quickly recaptured by a great convergence of police including the squad closely following the ambulance. The patient was ultimately transported to hospital in a police squad. The ambulance crew followed police to the hospital after the patient's elopement from ambulance.	This event was all the patient's responsibility and choice. The crew acted appropriately in all their actions including allowing the patient to escape safely while the vehicle was stopped and assuring that he did not fall going out the side door, which is an 18 inch step. The patient initially presented as totally cooperative with no risk and the crew did not anticipate the sudden change and elopement.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
8	During an attempt to move a combative, thrashing, altered LOC patient weighing 300+ lb., from a recliner to the stretcher, his pants ripped causing 2 of the 4 lifters to drop the patient a short distance to the carpeted floor. The stretcher was positioned 3-4 feet from patient. The patient's buttocks, upper back and the back of his head mildly struck the carpet floor with no change in the patient's status and no apparent harm. The crew then moved the pt. to the wheeled stretcher using a [brand name] soft-stretcher device, 6 lifters, and completed transport to the hospital.	1. The crew thought thru their plan in advance and identified how to best make a difficult patient move, yet had not anticipated that the clothes would tear. 2. 'Sliding' rather than 'lifting' a 300+ lb. patient is always a safer option for the patient and the providers. The crew and the police officer who had helped self-reviewed and debriefed this event and felt they had few other moving options due to patients weight and position in chair. They decided next time to not rely on integrity of clothes & discussed sliding across to the stretcher rather than lifting all the patients' weight.
9	75 y/o female was transported to [city] ER from [town] the morning of 9/9/14. Patient had been taking 4mg Dilaudid for elbow pain, but this was causing hypotension so was started on 2mg oral Dilaudid, which wasn't relieving her pain. Patient c/o feeling dizzy and sick from the medication. Patient had no recent trauma to the extremity. Patient was given 2mg IV Dilaudid and 100 mcg fentanyl in addition to the 2mg oral Dilaudid she had taken at home. Upon arrival to the ER, the patient's sats were in the 80's, GCS of 14. This amount of medication for this patient could have caused the patient to respiratory arrest.	This ambulance service needs more education on narcotic pain medication. More education and policy review of IV narcotic administration.
10	After a successful "defib test" of the Service Loaner monitor/defibrillator, it failed to deliver a shock to a victim of sudden cardiac arrest. The crew was able to immediately switch monitors after a quick trouble shooting period.	Monitor/defibrillator provided an error code indicating an internal unit problem with the device. This event confirmed the need for redundancy of equipment on scene. This practice allowed for seamless transition to a different device and patient care was not compromised.
11	Elderly female patient was being wheeled in to the Emergency Room from the ambulance bays. As the attendants were pushing the stretcher it began to skew sideways and 'dog walk' until it hit a small edge in the concrete and tipped the stretcher over. The patient experienced a head injury as well some bone and soft tissue injuries.	Temporary loss of focus when wheeling the cot. Attendants were not vigilant to the potential loss of stability when the cot was being wheeled on a sideways slant as opposed to proper wheeling alignment. Review stretcher safety. Stress the importance of vigilance and the need to maintain alignment when wheeling a stretcher with a patient on board.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
12	While moving a 73 y/o patient's sleeve to access left arm for IV, the crew discovered a newer appearing skin tear that may have been caused when crew carried her out of residence. Pt. was anxious and thrashing arms as she was carried through the home on a LBB. Pt. had other recent skin tears from a fall & being picked up after another fall 12 hours earlier. Unclear when or how this new skin tear occurred. Crew bandaged 1" x 2" skin tear and reported this finding to receiving hospital. Unable to determine exactly what caused this new wound for a patient with generally fragile skin.	A combination of factors: 1. Patient had fragile skin 2. Difficult carry to the ambulance 3. Patient reaching out and flailing arms during the carry. The exact time when the skin tear occurred could not be determined. In hindsight, should have considered restraining patient's arms more firmly to avoid her injuring herself when flailing her arms.
13	A paramedic level crew was unable to print and read subsequent 12-lead attempts after the 1st acquisition contained significant ECG base-line artifact that was unacceptable. The paper in the ECG chart printer then jammed when the crew attempted other acquisitions. Error messages on monitor screen now identified a printer malfunction they were unable to correct. No harm to this chest pain patient with possible STEMI who was transported direct to a cath lab. The crew correctly diagnosed the AMI based on other clinical manifestations and the patient's cardiac history.	1. The ECG paper printer is prone to jamming if the paper is not torn off carefully 2. The ECG baseline artifact was likely due to the patient's diaphoretic skin and poor adherence of the electrodes. 3. It is also possible that the patient ECG cable was faulty contributing to the artifact. The monitor manufacturer should improve the engineering and reliability of the ECG printer which needs to work on this model for the crew to view the machine 12-lead interpretation. Otherwise, design the monitor so the crew can view the ECG results without the printer working.
14	A cardiac monitor initially failed to acquire a 12-lead displaying an error message of V-4 lead off. The crew was able to determine the failure was due to a faulty ECG cable and were able to quickly obtain a replacement cable and were then successful at acquisition for this patient. The interpretation was not an MI and the patient ultimately refused treatment and transport with no harm.	Failure of main patient ECG cable. Cables provided by manufacturer do not hold up to the rigors of the EMS environment and are subject to wires breaking.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
15	I reported a structural fire in an apartment complex. While I'm the Chief EMS Officer, I'm also a firefighter, and lacking additional crewmembers, chose to board an understaffed engine, as the first unit out, and have mutual aid handle EMS. I assisted in the rescue of a victim. The victim was altered and had an SPCO level of 37%, despite the device being applied five minutes after I began giving high flow oxygen. We carried the patient on the board to the arriving ambulance, and the driver went to fight the fire. I drove the ambulance to a near by church where I had requested a medical helicopter to land prior to packaging for transport. In the 45 seconds or so we drove to the LZ, I heard the EMT screaming at the patient. Upon staging, I exited the cab and ran to the curbside and entered the back. The EMT had not even started assessment. I assessed the patient's vitals, and added dressings to ones that were bleeding through; then applied dry burn dressings to areas I had previously doused with saline. I noted the patient had airway compromise from burns, and the saturation was not improving, instead, falling. The patient kept pulling the oxygen mask off, gasping for air. I calmly sat down and spoke to the patient, whom I've known for years, and we had a good rapport going on, till the EMT that came with the mutual aid ambulance became disgruntled over the patient pulling the oxygen mask off. I attempted to suction the patients mouth, and had the Yankauer pulled out of my hand, and was told it's too expensive to use the on board suction. While the EMT was trying to get the portable suction to work, the patient said he was going to be sick, so I rolled the board, and he coughed up a large glob of black sputum, which struck the side wall of the patient mod. The EMT slammed the board down, out of my hands, grabbed the oxygen mask, and with his arm straight and with force, pushed it down on the patients face, and began cursing that the patient needed to calm down, and quit spitting. I grabbed the EMT's arm, and told him to sit down or leave the ambulance. He let go, and the patient began screaming and crying, pleading that the other EMT not touch him, again, he removed the oxygen mask. Mind you, both arms are burned and full of glass. The other EMT grabbed the patients arms, pulling dressings - and skin off the burned areas, and screamed at me to tie his arms down. I told him to get out of the ambulance, or I'd have his certification revoked. He sat down and refused to assist. The patient was sedated and intubated and did not remember the events prior. [Report shortened to fit this space.]	The provider, a 75 y/o male, is not fit to perform as an EMT any longer. He is not capable of assessing situations, and treating patients in critical circumstances, without becoming overwhelmed very easily. I believe that he has become a more of a danger to the public. [Personal identifiable information redacted]

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
16	While treating a pediatric seizure patient I accidentally gave Diltiazem rectally, instead of Diazepam rectal.	I miss read the vial and the normal warning flags didn't trigger in my mind. Not sure of any.
17	Monitor initially failed to acquire 12-lead with V-2 lead off error message. Later, able to acquire yet unacceptable due to V-2 artifact and acute MI machine interpretation was incorrect. Patient complained of chest and back cramping type pain. Determined to not be cardiac in origin and no harm to patient. Equipment removed from service.	The main patient ECG cable found to be faulty & produced only artifact for V-2 tracing. The break in cable was near proximal plug & intermittent. 12-lead interpretation by the machine was incorrect due to artifact & unacceptable 12-lead tracings. Our service experiences ECG cable failures frequently. The cable tested faulty for poor signal quality from the V-4 lead wire. This was a good catch by the crew who noted that the 12-lead tracing was unacceptable and incorrect due to the baseline artifact.
18	While moving a 73 y/o patient's shirt sleeve to access the left arm for IV, the crew discovered a newer appearing skin tear that may have been caused when crew carried her out of residence. Pt. was anxious and thrashing arms as she was carried through the home on a LBB. Pt. had other recent skin tears from a fall & being picked up 12 hours ago. Unclear when or how this new skin tear occurred.	Unable to determine exactly what caused this new wound for a patient with generally fragile skin. The skin injury likely occurred while the crew was making the difficult move to the ambulance. In hindsight, firmly tying the patients arms down or using arm restraints might have prevented the new skin tear. Any option tried would be difficult due to the patient's anxiousness and thrashing.
19	A cardiac monitor on a scene response failed to acquire a 12-lead with multiple error messages displayed on the screen indicating problems with lead V-2 & V-3. The patient had a cardiac history with a complaint now of chest tenderness which was aggravated by movement. No harm to the patient who was transported non-emergent.	The main patient ECG cable was tested & found to have faulty or damaged wires. The ECG cable was replaced, tested OK, and the cardiac monitor was returned service. Supplied ECG cables do not stand up to the rigors of use in the EMS environment.
20	A monitor failed to acquire a 12-lead ECG for a cardiac related chest pain patient with a paced rhythm. Error messages on the monitor screen indicated V leads off. The ECG tracing had frequent base-line artifact & periods of no signal. No delay to transport and no harm to patient who was declared a pre-hospital STEMI activation & eventually did go to the hospital cath lab for confirmed artery blockage.	The main ECG patient cable was tested & found to have a faulty main wire near the proximal plug which was replaced and returned unit to service. Additional testing revealed a faulty LL/green/grounding electrode snap which was also contributing to the artifact. Supplied ECG cables do not stand up to the rigors of the EMS environment.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
21	After obtaining successful vein canulation for TKO IV access, the administration set would not prime or flow. Crew unable to trouble-shoot & opted for saline lock IV access. No harm to patient who was transported for possible problem with their implanted IV medication device and confusion.	Examination of the administration set revealed that the distal end extension set added by the crew to the catheter hub was cross-threaded and not seated properly to open the valve and allow fluid flow. Repositioning the connection corrected the problem. No product failure. Some IV administration tubing now have valves in the receiving connectors. If the male connector is not seated deeply enough into the valve, flow can be prevented or restricted. Some providers have also reported that certain 60-drop administration sets do not work with some extension sets because the connector is too short to open the valve. If products from different manufactures are mixed, additional incompatibilities may be discovered.
22	On a scene response, the crew was unable to print and read subsequent 12-lead attempts after the 1st acquisition printed contained significant ECG base-line artifact making it unacceptable for interpretation. During the next attempt, error messages on monitor screen now identified a printer malfunction they were unable to correct. No harm to chest pain patient with a possible STEMI who was transported direct to the hospital cath lab.	The inability to acquire and interpret a 12-lead successfully had two causes: 1. The V-lead artifact was due to a faulty main ECG patient cable which was later replaced; 2. The chart printer paper became jammed which prevented the crew from viewing additional 12-lead acquisitions. The ECG cable failure problems are a frequent occurrence. The paper jam in the printer door was likely due to the crew not being careful enough when tearing off the 1st 12-lead that did print out. This monitor requires the 12-lead to print for the crew to view the machine interpretation. The manufacturer should redesign so the crew can quickly see and read the 12-lead even if the printer fails.

Notice/disclaimer: all manufacturer and model names are removed from this document because EVENT is an anonymous system. The anonymity of EVENT reports is protected and the reporter cannot be verified as a neutral party trained to provide a fair and unbiased assessment of the events or product usage. For this reason we redact all names, including the manufacturer and model. We operate another reporting system, the Emergency Medical Error Reduction Group (EMERG), which can provide states or individual EMS agencies a non-anonymous error reporting system. As a designated Patient Safety Organization (PSO), EMERG has federal discovery protection for all information entered and analysis completed. EMERG can help identify actual manufacturing issues and partner with industry to correct issues and thereby improve the culture of safety in EMS. For more information please about EMERG, contact Matt Womble, MHA, Paramedic, Director of EMERG (matt.womble@emerg.org). (EMERG is federally designated as PSO # P0133 by the U.S. Department of Health and Human Services, Agency for Healthcare Research & Quality.)

THIRD QUARTER 2014

E.V.E.N.T. Provider Violence Report

Welcome!

Welcome to the EMS Voluntary Event Notification Tool (E.V.E.N.T.)!

This is an aggregate report of the provider violence events reported to E.V.E.N.T. for the third quarter of 2014 (July through September 2014). We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected will be used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool (Patient Safety Event, Near Miss Event, Violence Event, Line of Duty Death). The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

"… patient was able to wriggle out of restraints multiple times and each time became combative, attempting to harm providers… Patient made multiple threats to providers stating she intended to kill them …." – 3Q2014 EVENT Provider Violence Report #3

This is the aggregate Provider Violence E.V.E.N.T. summary report for Third Quarter 2014.

PROVIDED BY:

The Center for Leadership, Innovation, and Research in EMS (CLIR)

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada / Chefs Paramédics du Canada

NATIONAL EMS MANAGEMENT ASSOCIATION

NAEMT

NASEMSO

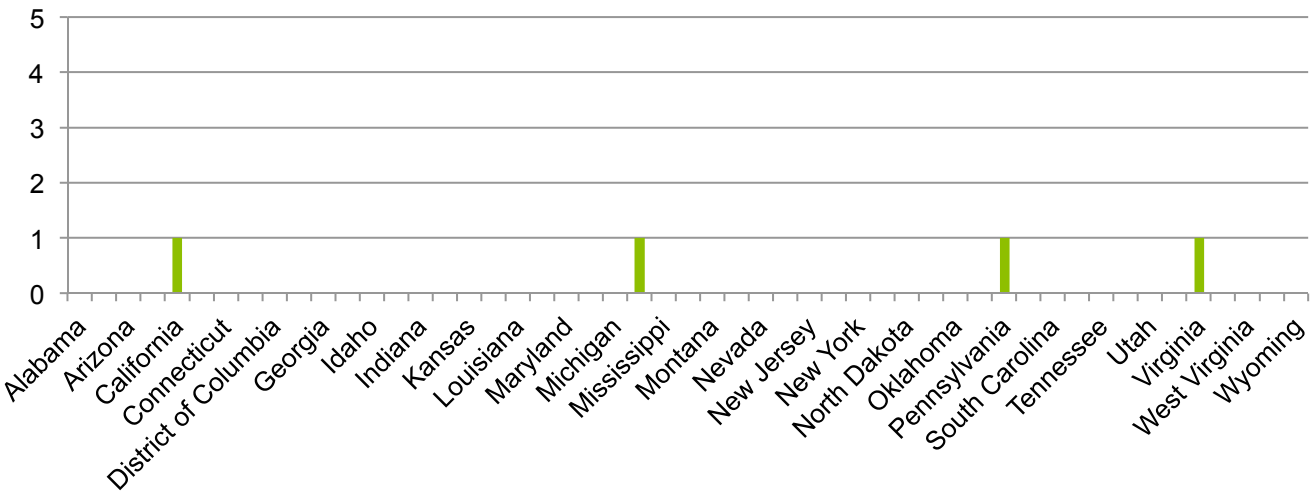
Table 1: Violence Events Quarterly

	2012	2013	2014
Jan - Mar	1	3	10
Apr - Jun		5	5
Jul - Sep	9	18	5
Oct - Dec	11	10	
Total	21	36	20

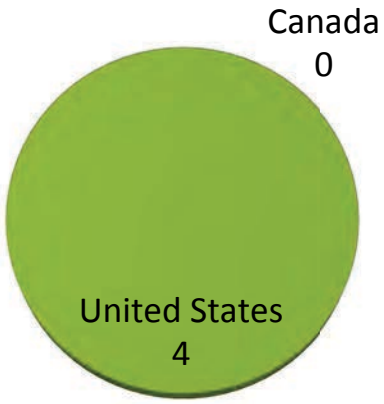
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

When an anonymous EVENT report is submitted, our team is notified by email. In the United States, the anonymous event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

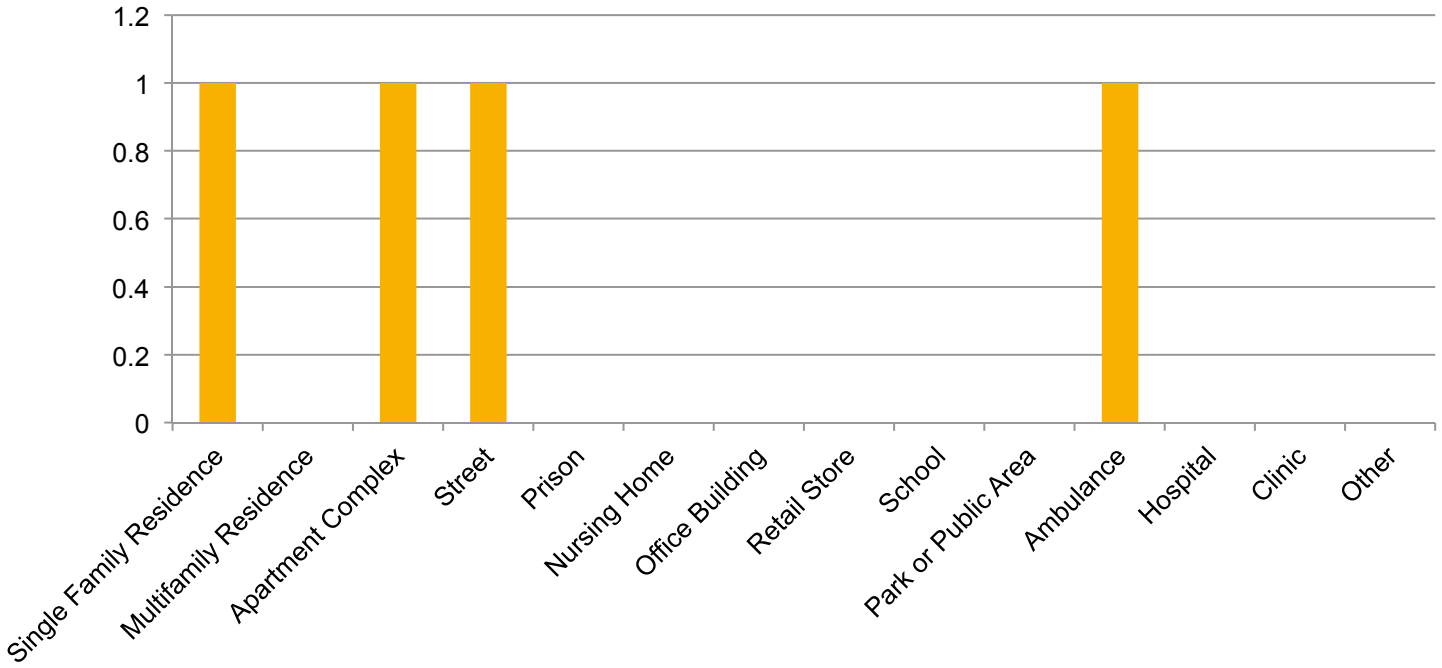
Violence Events by State



Quarterly Violence Events by Country



Place Violence Occurred




Alabama Emergency Medical Technicians Association


NAEMSP


CAA
HEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE


NAEMT


National Registry of Emergency Medical Technicians
THE NATION'S EMS CERTIFICATION


NATIONAL
EMS
MANAGEMENT
ASSOCIATION


National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE
NEW YORK STATE
ASSOCIATION INC.


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION


VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health


AAMS


THE UNIVERSITY OF ARIZONA
MEL AND ENID
ZUCKERMAN COLLEGE
OF PUBLIC HEALTH
Center for Rural Health

Figure 4: Victim Age

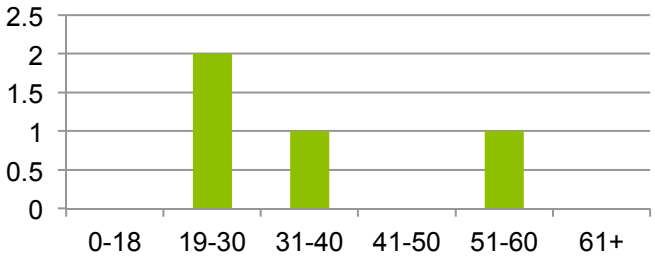
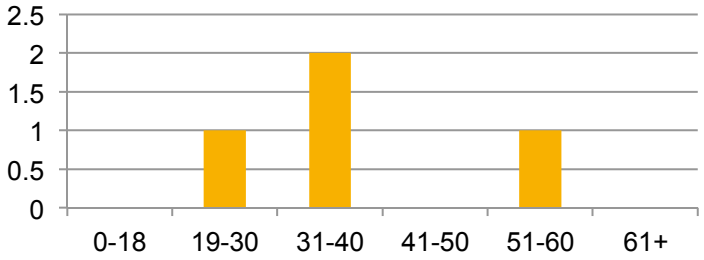
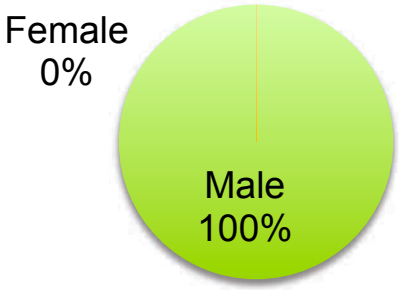


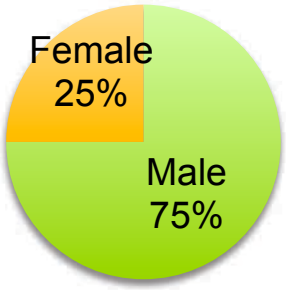
Figure 4A: Assailant Age



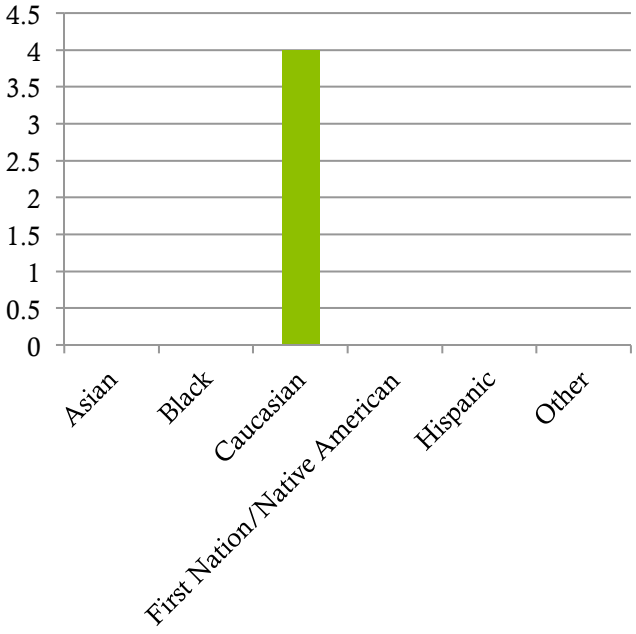
Victim Gender



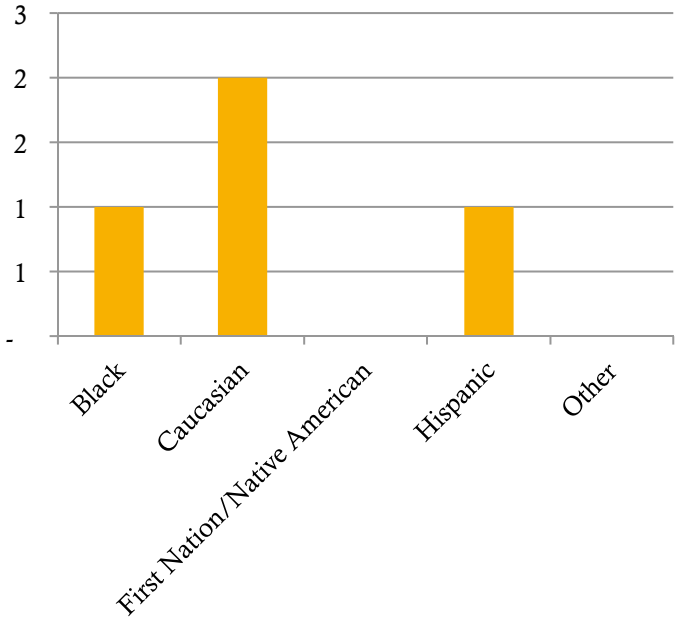
Assailant Gender



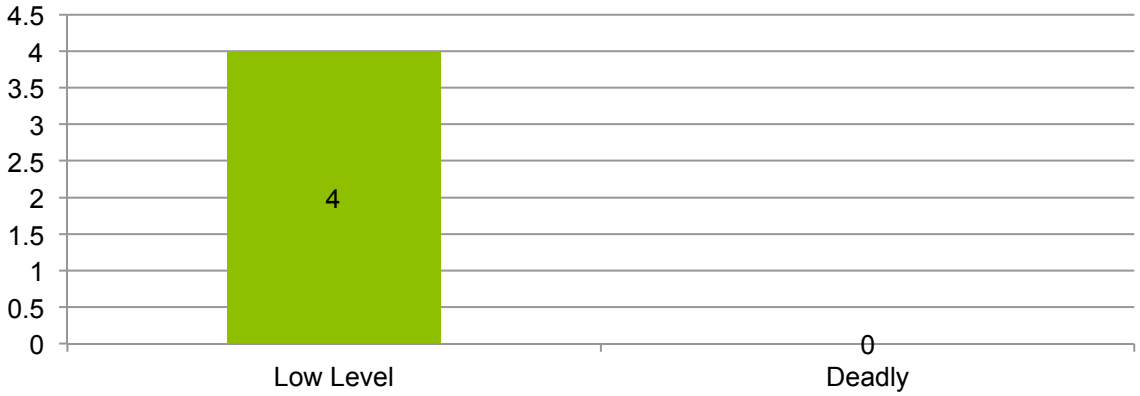
Victim Race



Asssailant Race



Paramedic's Perception of Harm



Type of Victim Injury

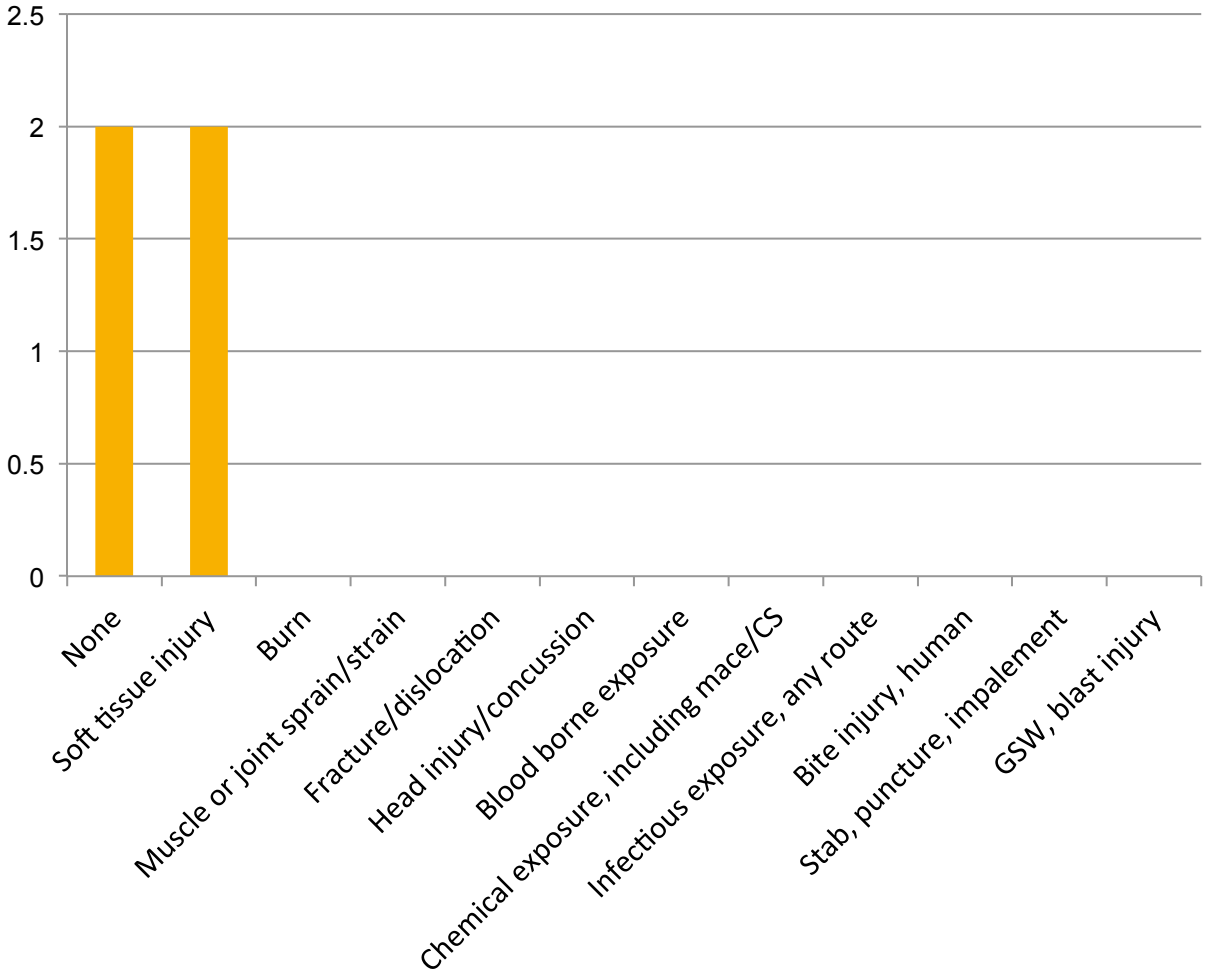


Figure 7: Type of Victim Treatment

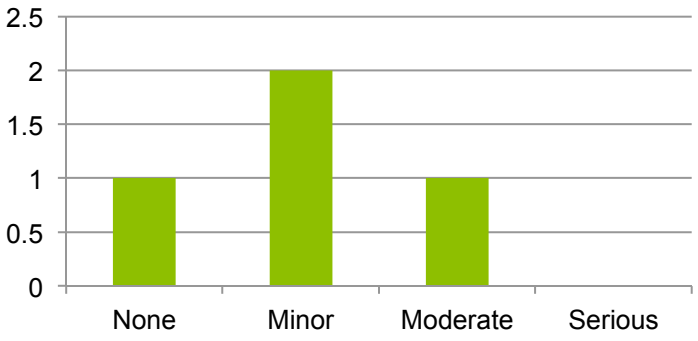


Figure 8: Method of Assault
Note: Multiple Options Reported

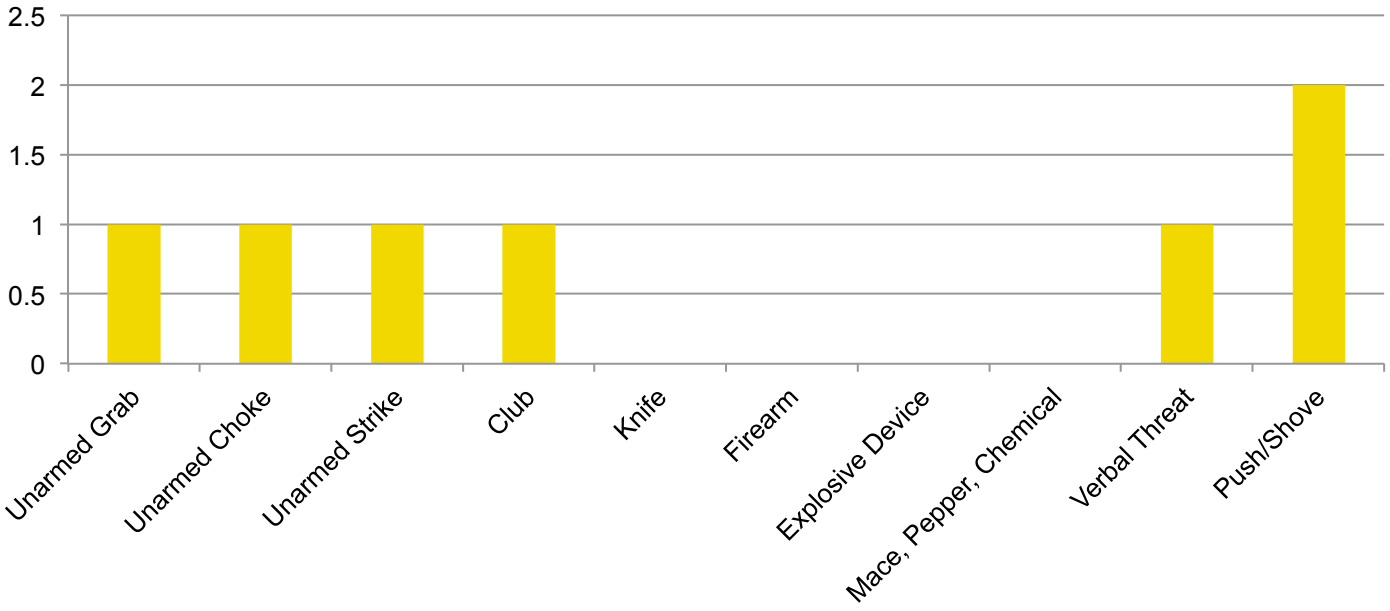


Figure 9: Internal Agency Report Filed

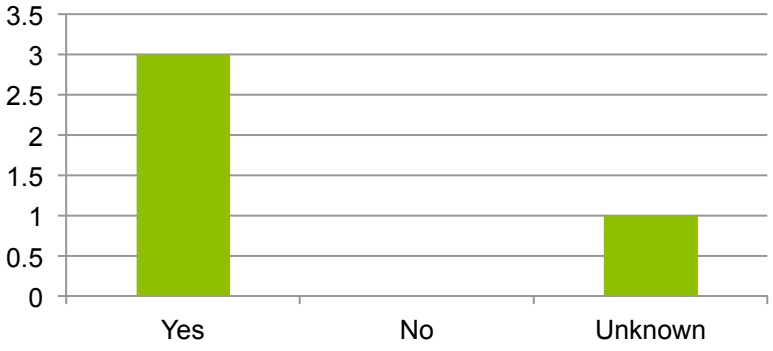


Figure 10: Law Enforcement Present or Notified

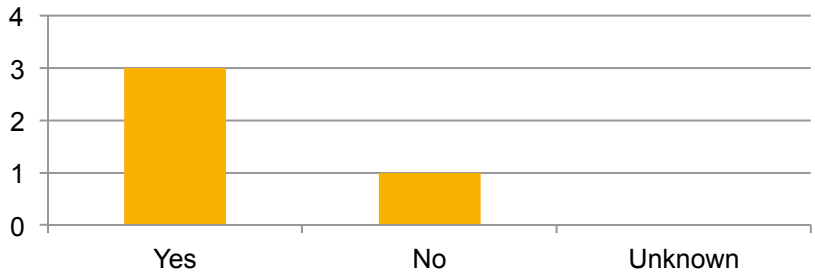
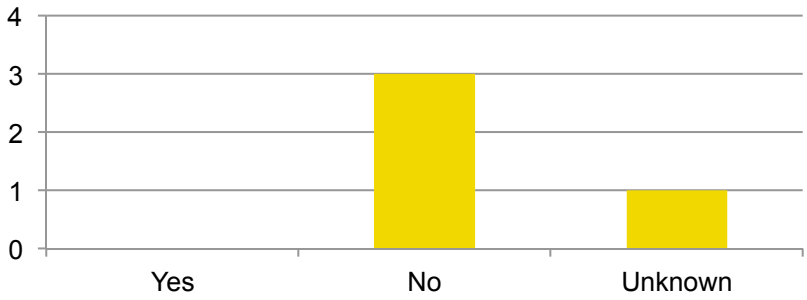


Figure 11: Assailant Arrest



#1	Patient became unruly/combative during transport. Patient threw her belongings in the air, and starting bouncing up and down onto the litter. Patient was screaming while un buckling herself from the stretcher. In the mean time my partner backed the ambulance into the hospital, and made contact with security.
#2	Responded to a report of a subject unresponsive on a lawnmower. Neighbors called 911 and stopped the mower. U/A found neighbors and patient's wife caring for him and trying to feed him banana and OJ. Crews approached and using implied consent checked patient's blood sugar that was 11. Patient started being combative and crews prepared glucagon. The needle was injected then subject appeared to have an increased mental status (enough time for the bananas and OJ to kick in) then pushed paramedic away before any medicine was injected. Pushing the paramedic away caused the needle to stick paramedic in the finger. Patient got up and said he didn't need us and went into house. Patient refused to be tested. Paramedic had to go to ER and get treatment and was prescribed medicine to ward off any potential diseases.
#3	Arrived at apartment complex for unconscious unresponsive patient that was found prone in parking lot, GCS of 3 initially with strong carotid pulse and spontaneous respirations. PD states that patient fell from standing position to position found in. On rolling patient to back board, patient woke up and became extremely combative, attacking multiple members of ems crew and striking two of them, resulting in no injury to one and bruising to face on the other. Restrained patient to gurney, however, patient was able to wriggle out of restraints multiple times and each time became combative, attempting to harm providers. Patient smelled of ETOH. Patient made multiple threats to providers stating she intended to kill them. Patient calmed down at ER.
#4	An ETOH intoxicated patient in a residential foster care home for adults with mental health issues, became uncooperative & then combative while moving him to stretcher. The patient grabbed a crewmember's shoulder and threw a punch striking him around the left eye. The patient then grabbed the medic around the neck before he was subdued with the help of other fire service 1st responders & restrained to the stretcher for transport to hospital. A police report was taken at receiving hospital for this assault on EMS personnel.

CALENDAR YEAR 2013

E.V.E.N.T. Near Miss Report

Welcome!

Welcome to the EMS Voluntary Event Notification Tool (E.V.E.N.T.)!

This is an aggregate report of the near miss events reported to E.V.E.N.T. for calendar year 2013. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected will be used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool. The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

"…During my most recent ride out for the Paramedic program that I am currently enrolled in, I witnessed a "near miss" event. A paramedic on my shift made the mistake of almost administering a drug that was mentioned as an allergen by the patient moments before. My preceptor and myself immediately corrected him in an assertive but positive way…." – 4Q2013 EVENT Patient Safety Report #7

This is the aggregate Near Miss E.V.E.N.T. summary report for Calendar Year 2013.

PROVIDED BY:

The Center for Leadership, Innovation, and Research in EMS (CLIR)

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada / Chefs Paramédics du Canada

National EMS Management Association

NAEMT

NASEMSO

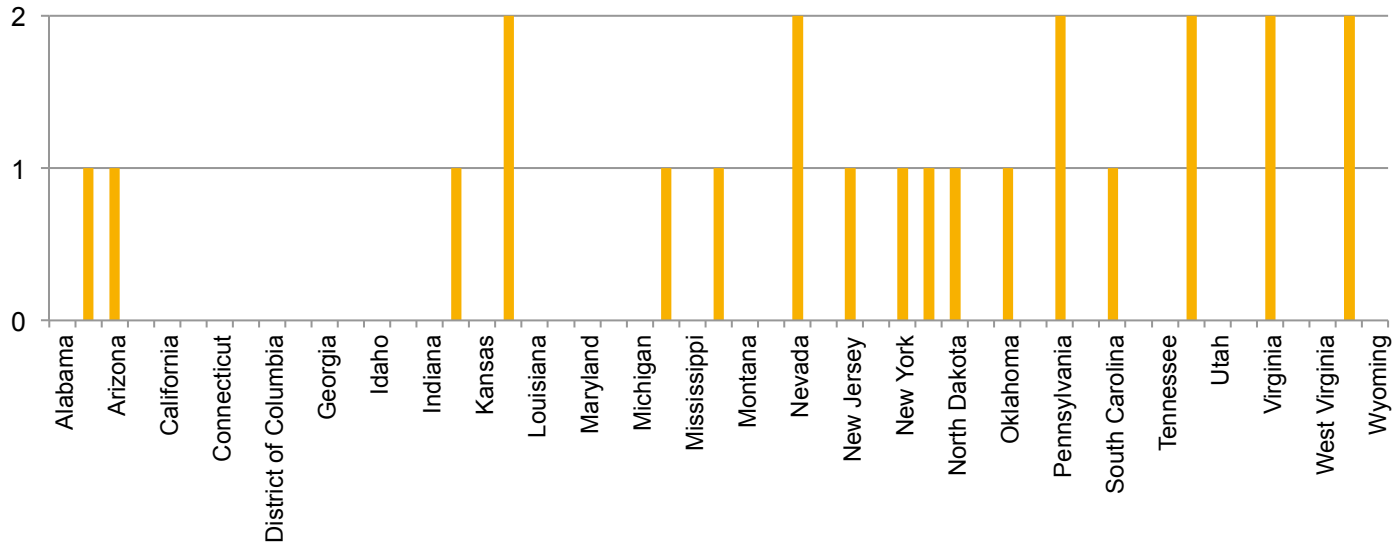
Table 1: Near Miss Events Quarterly

	2012	2013	2014
Jan - Mar		1	
Apr - Jun		6	
Jul - Sep	1	6	
Oct - Dec	4	8	
Total	5	21	

As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

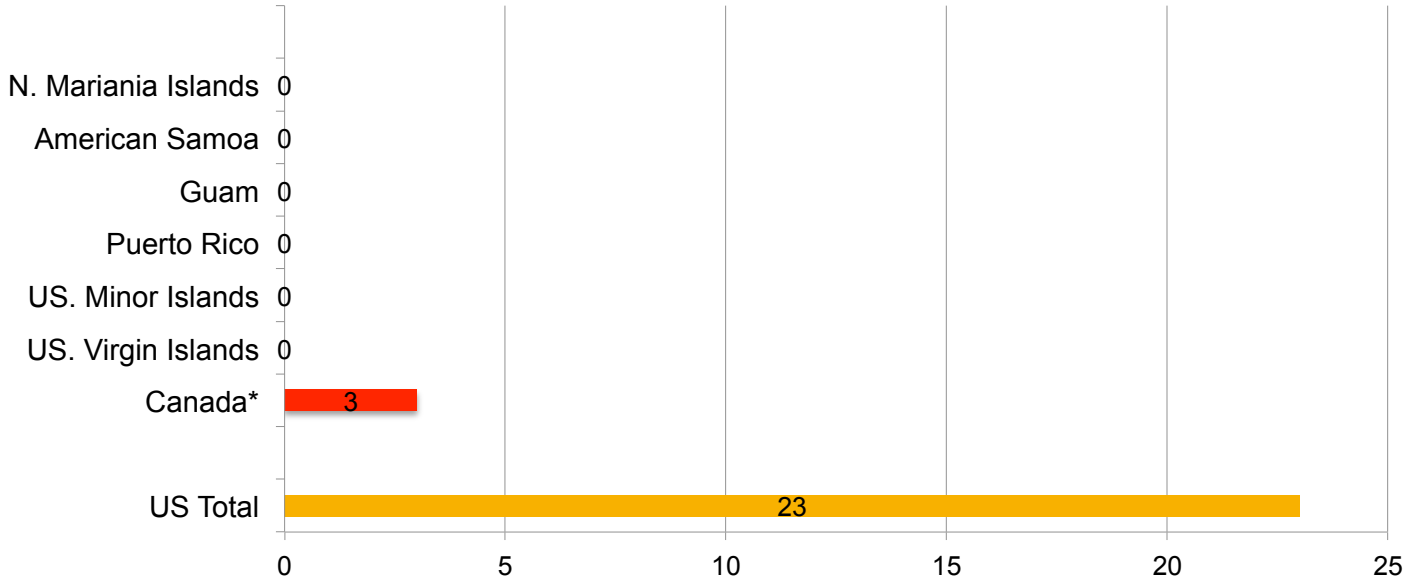
When an anonymous E.V.E.N.T. report is submitted, our team is notified by email. In the United States, the anonymous event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

Figure 1: Near Miss Events by State (United States of America)



THE UNIVERSITY OF ARIZONA | MEL AND ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

Figure 2: Quarterly Near Misses in Canada and U.S. Territories



Quarterly Frequency of Near Miss Events Across Agency Characteristics

Figure 3: Service Area

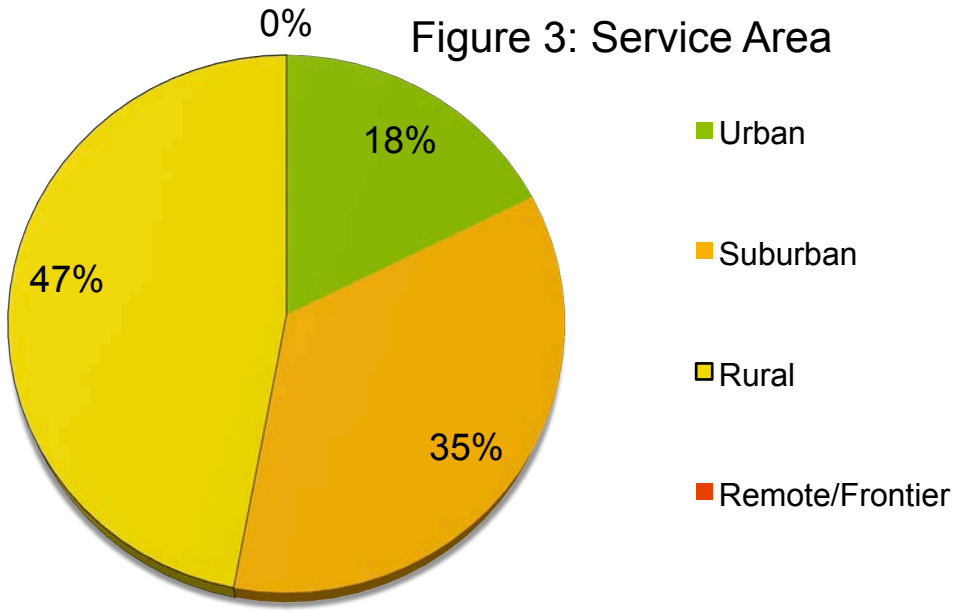


Figure 4: Frequency of NME by Agency Ownership

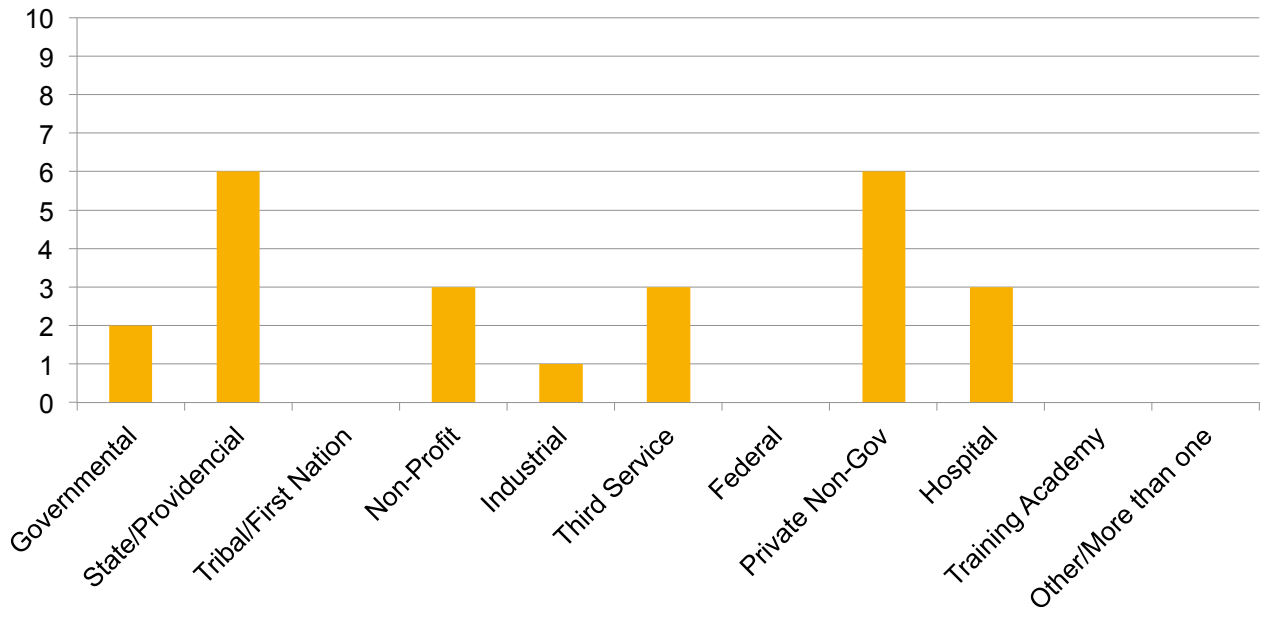


Figure 5: Department Type

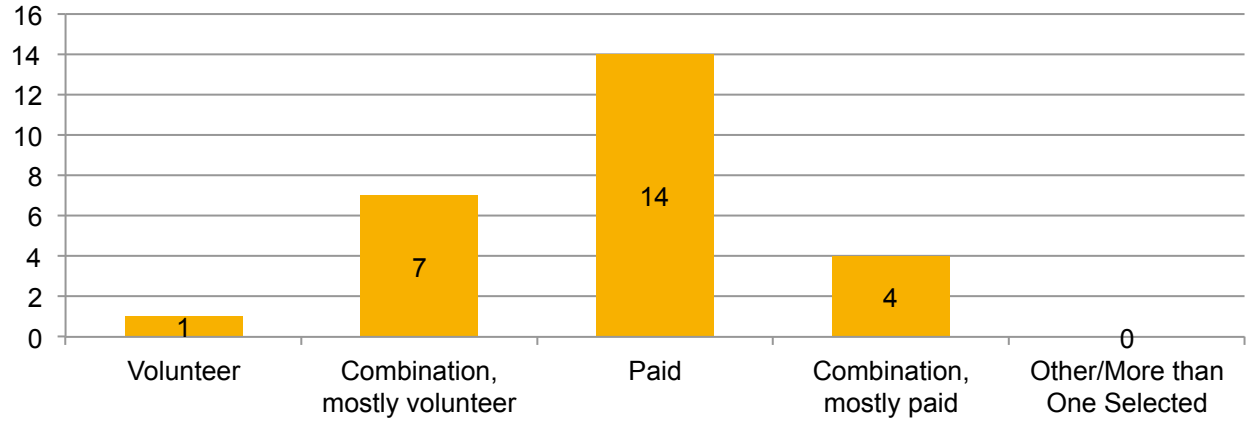


Figure 6: Level of Organization

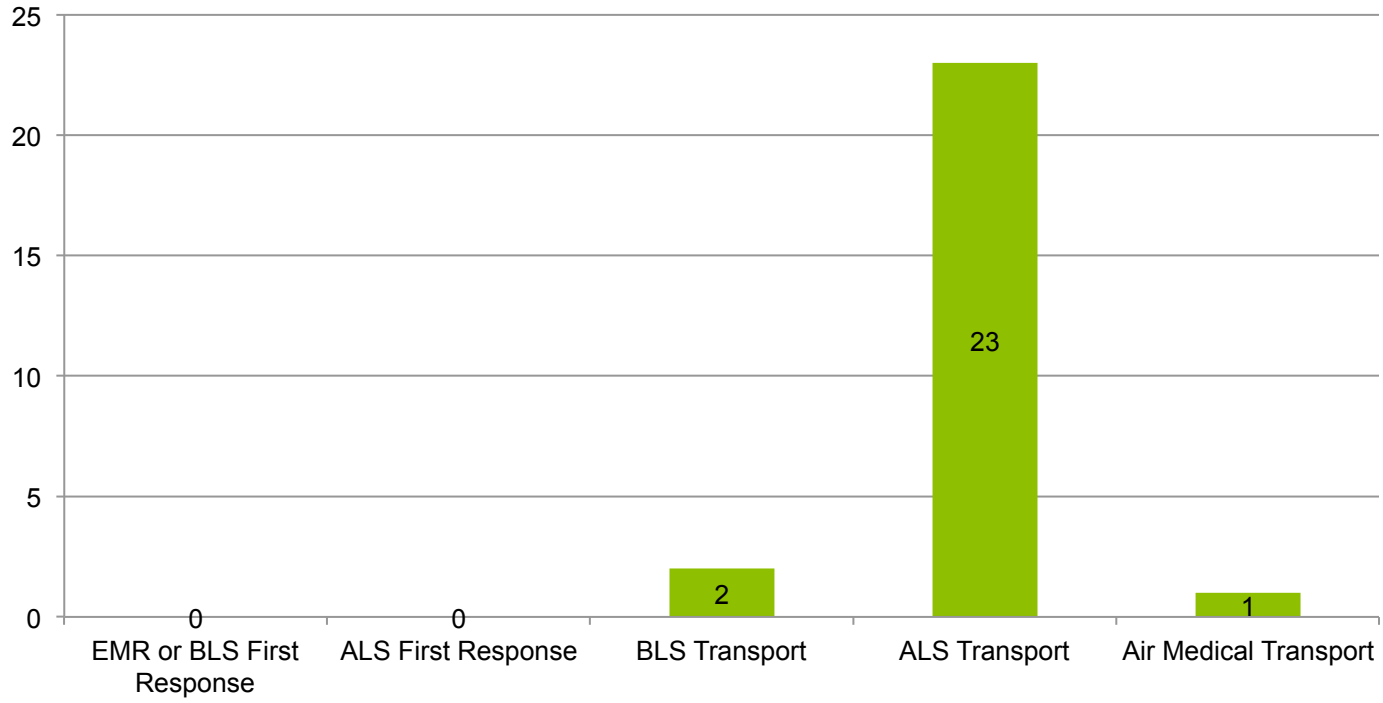


Figure 7: Employment

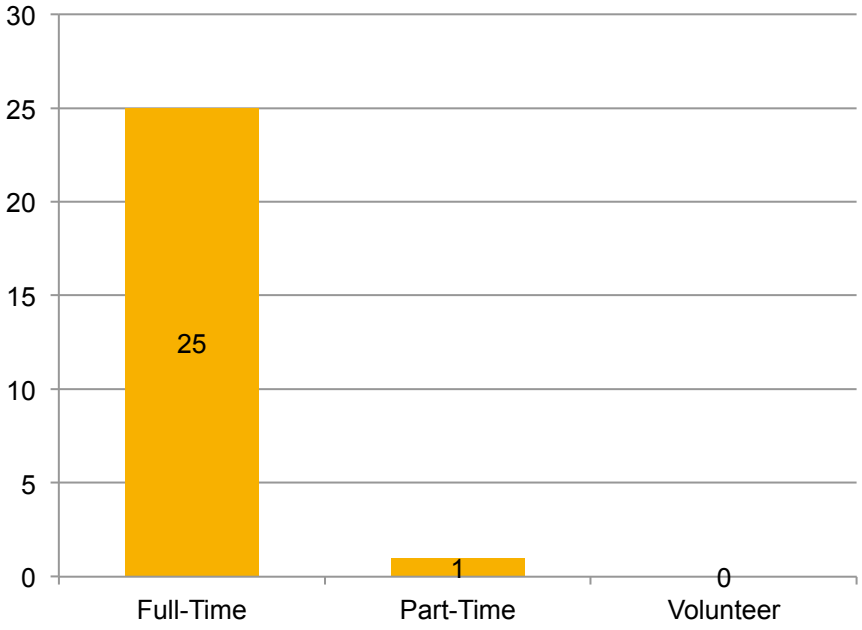


Figure 8: Annual Responses of NME Agency

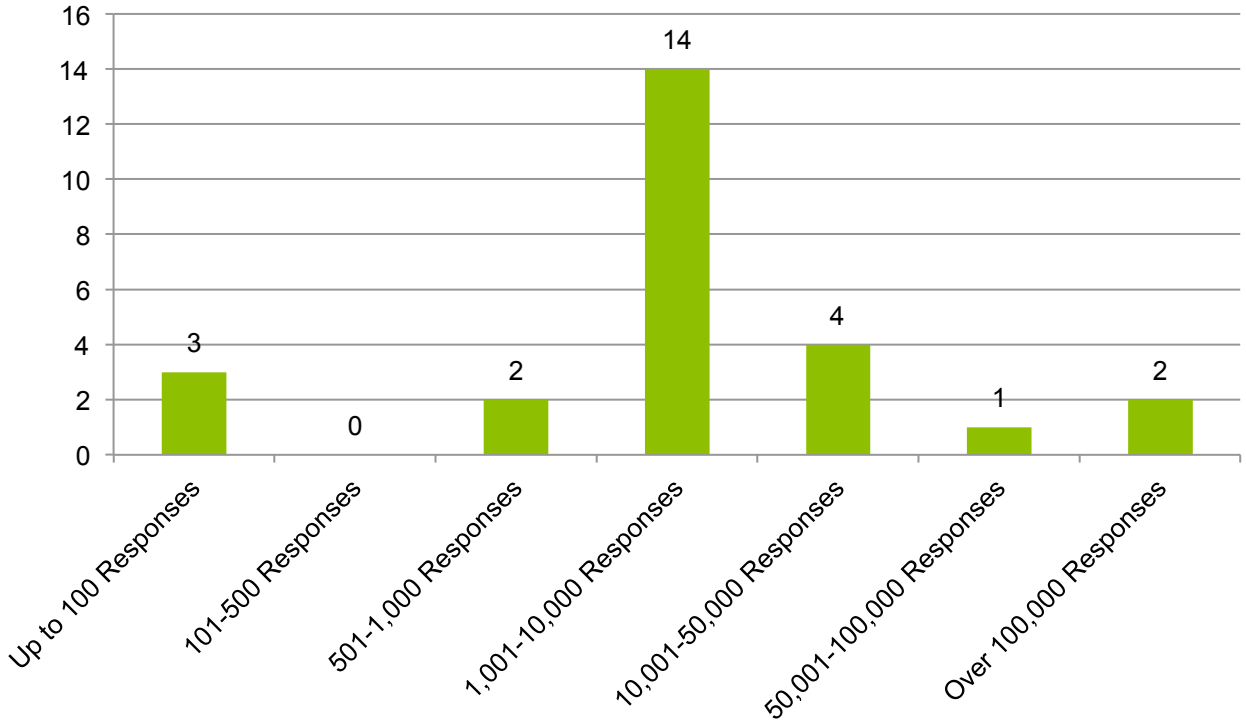


Figure 9: Near Miss Event Setting

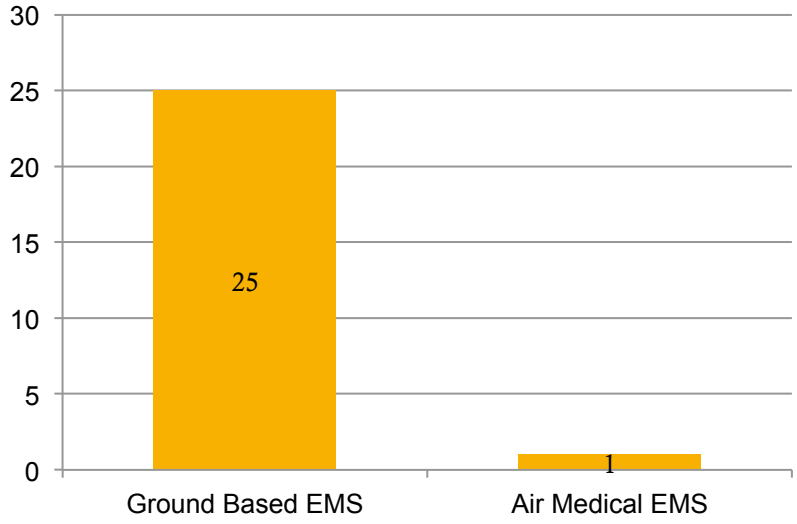


Figure 10: NME Occurrence During EMS Response Timeline

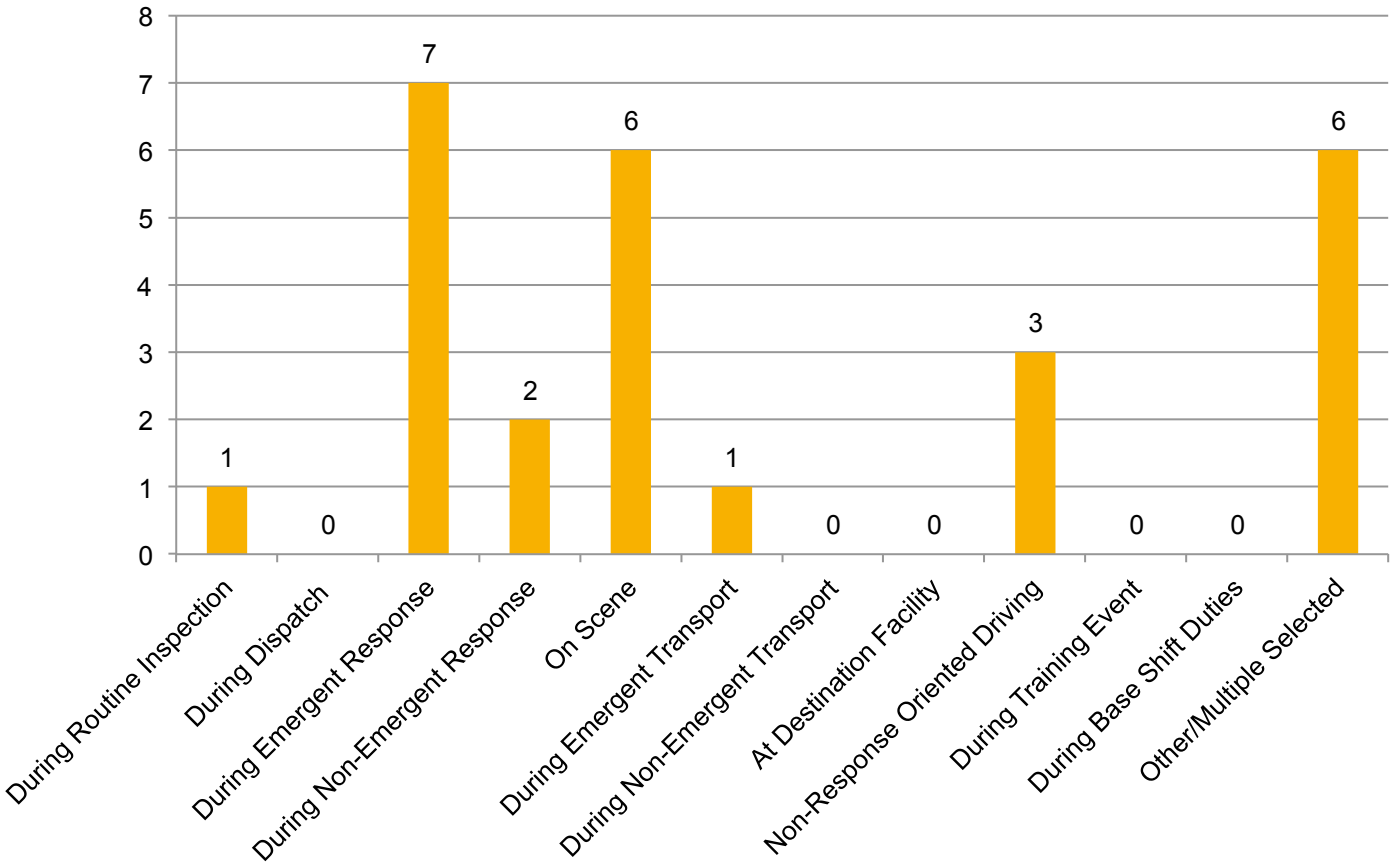


Figure 11: Year Reported Near Miss Event Occurred

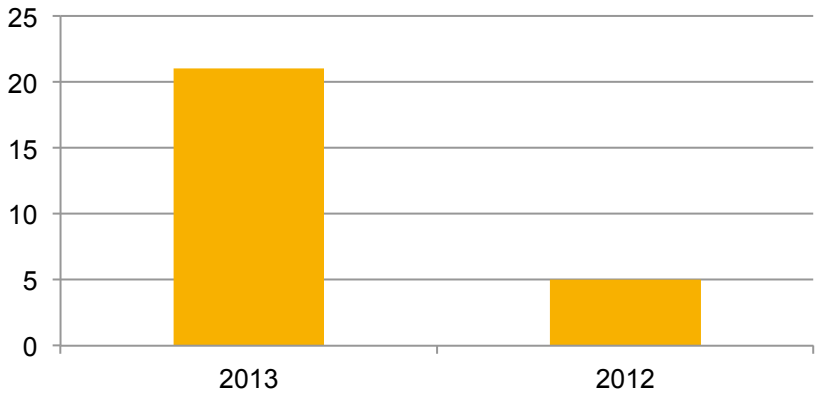


Figure 12: Month of Reported Near Miss Event

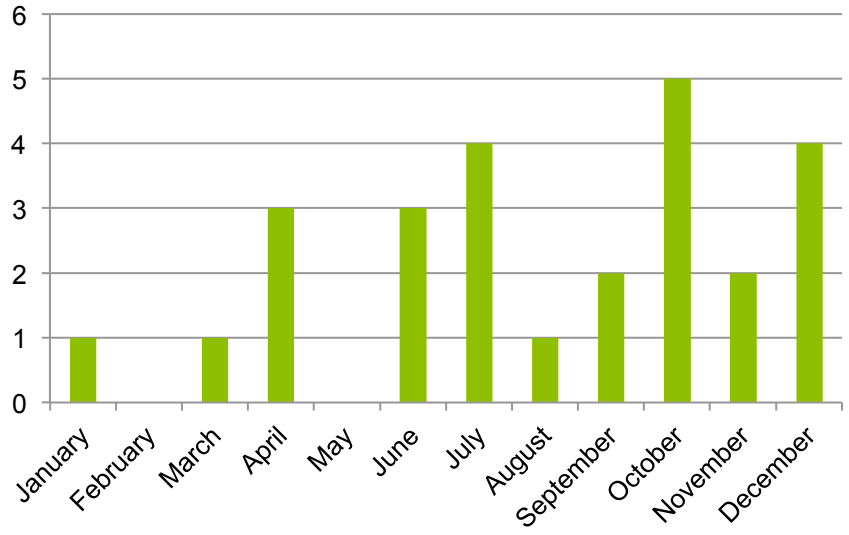


Figure 13: Time of Reported NME

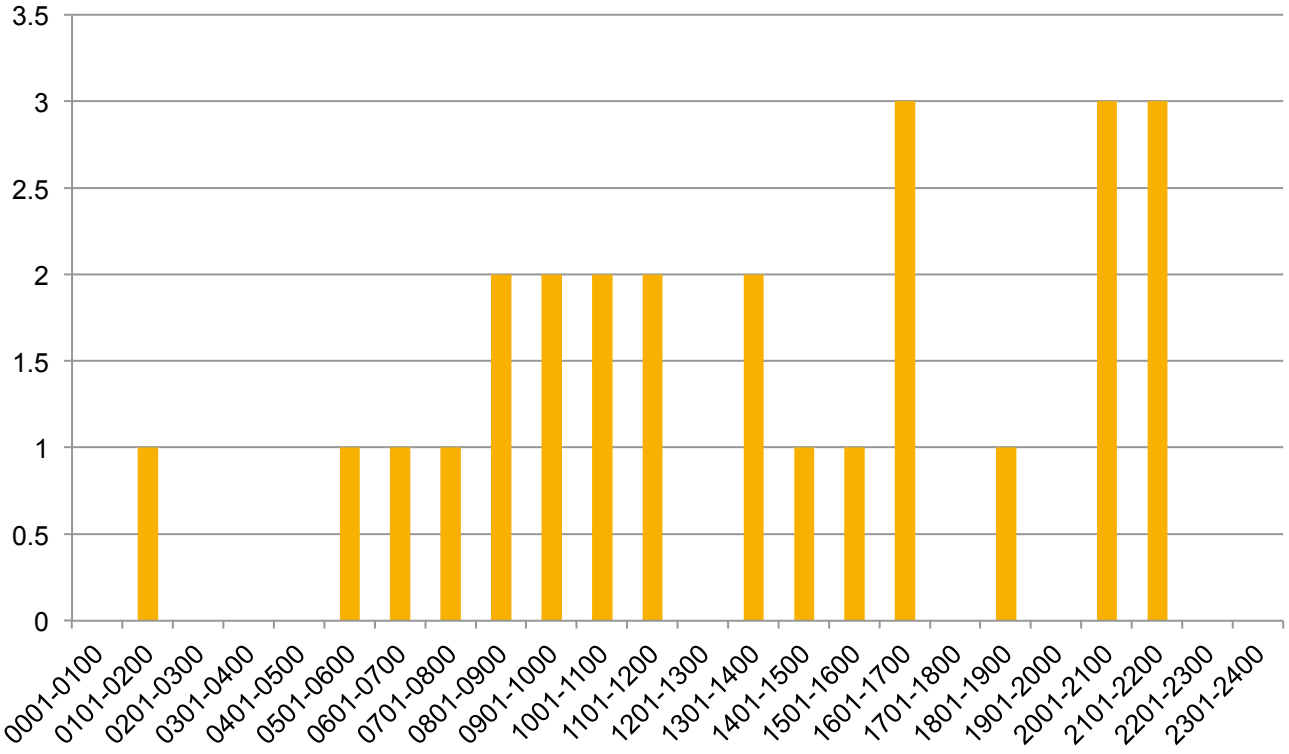


Figure 14: Environmental Visibility During Near Miss Event

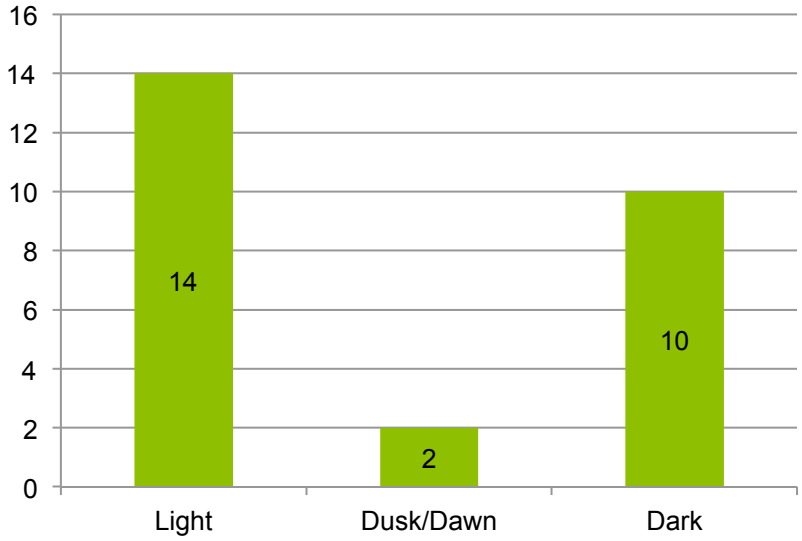


Figure 15: Weather During NME

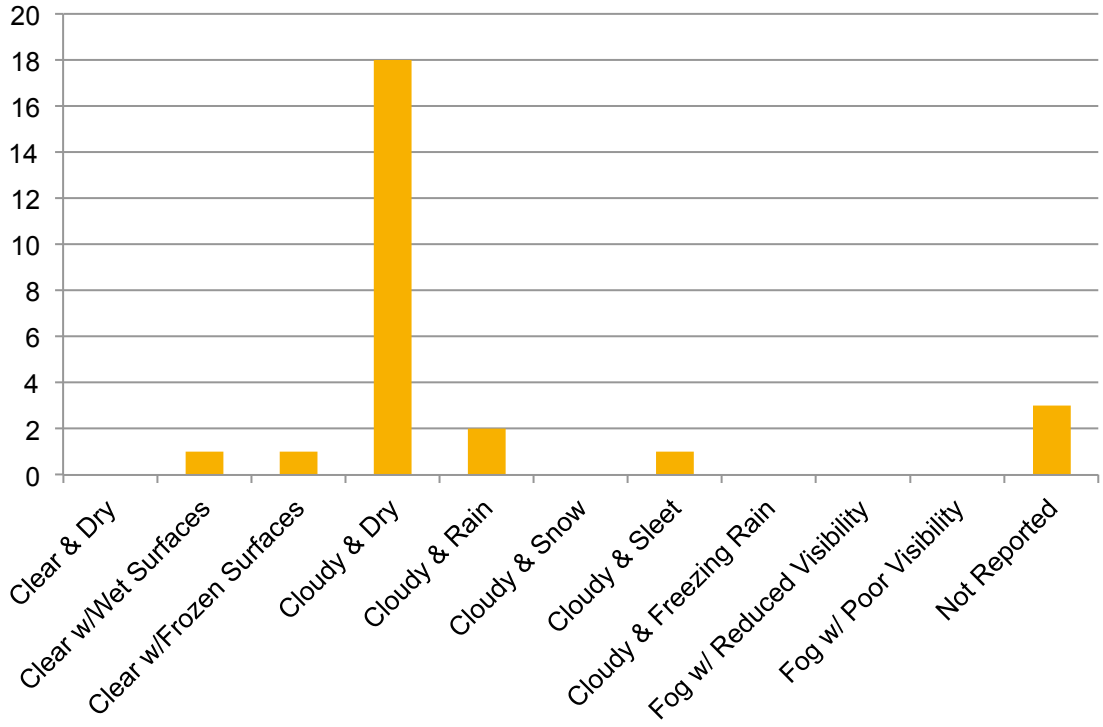


Table 2: Contributing Factors to Near Miss Events: As Reported by Providers

	Frequency		Frequency
Accountability	2	Situational Awareness	7
Command	0	SOP/SOG	0
Communication	5	Staffing	0
Decision Making	5	Task Allocation	0
Equipment	5	Teamwork	0
Fatigue	0	Training Issue	2
Distracted Driver/Pilot	0	Unknown	0
Horseplay	1	Weather	0
Human Error	6	Violent Patient	2
Individual Action	4	Violent Non-Patient	1
Procedure	0	Inadequate Lighting	2
Protocol	0	Other	0

Figure 17: Hours into Shift at time of NME

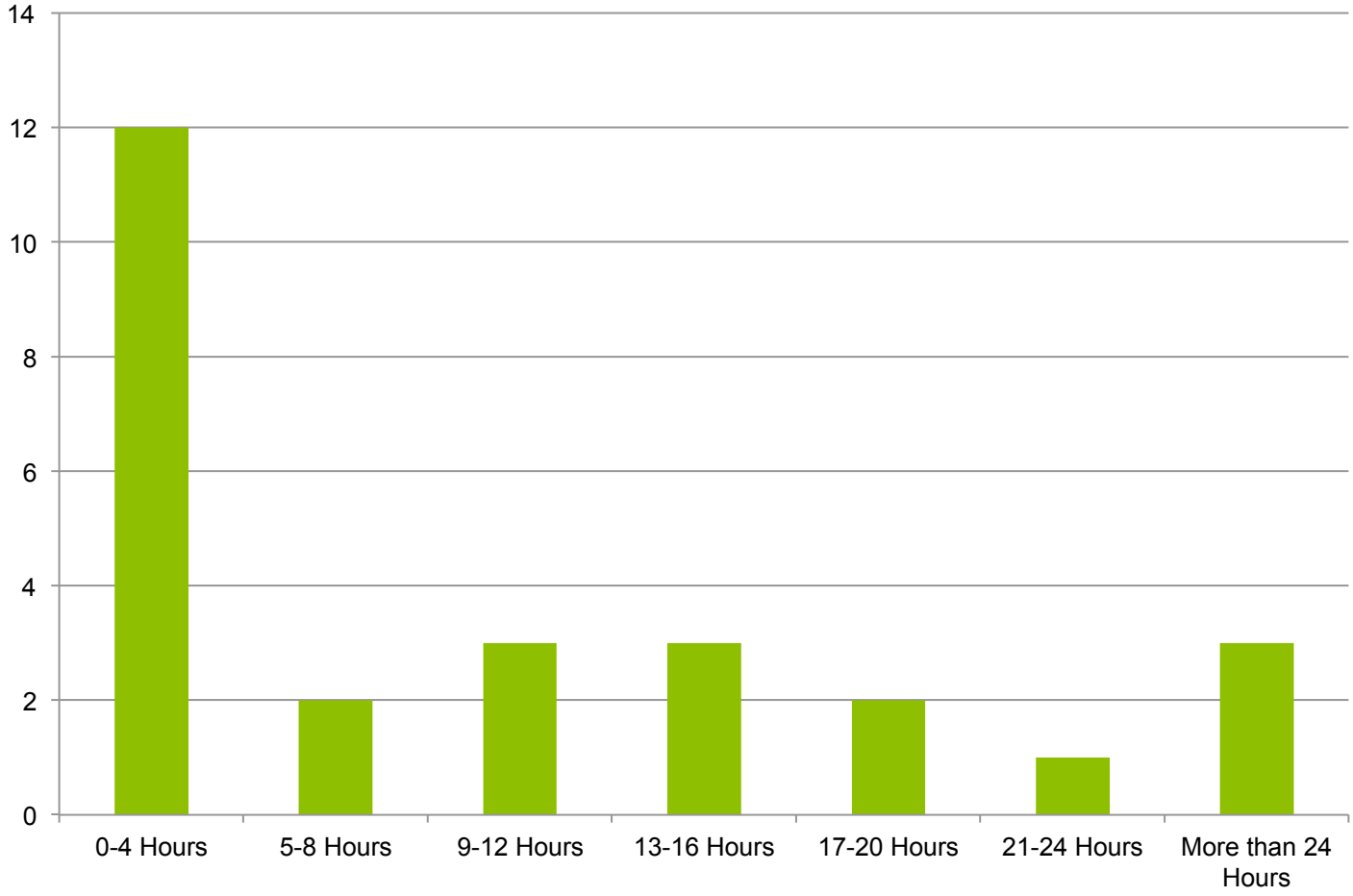


Figure 18: Time off before beginning of shift with NME

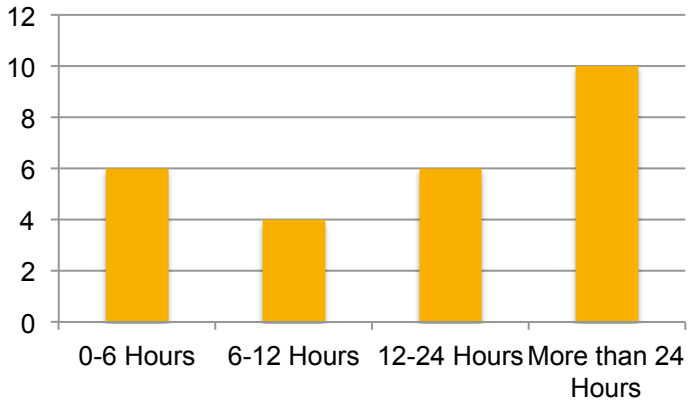


Figure 19: Rank of Provider in Near Miss Department

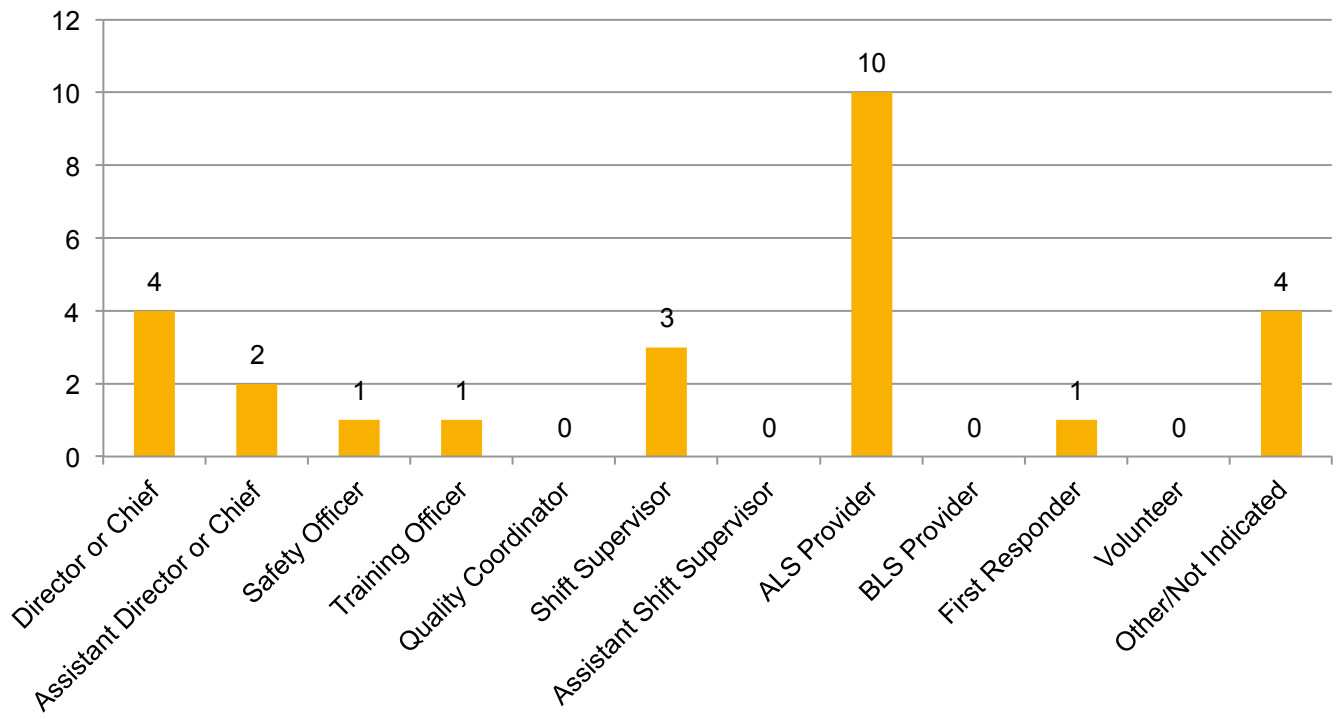
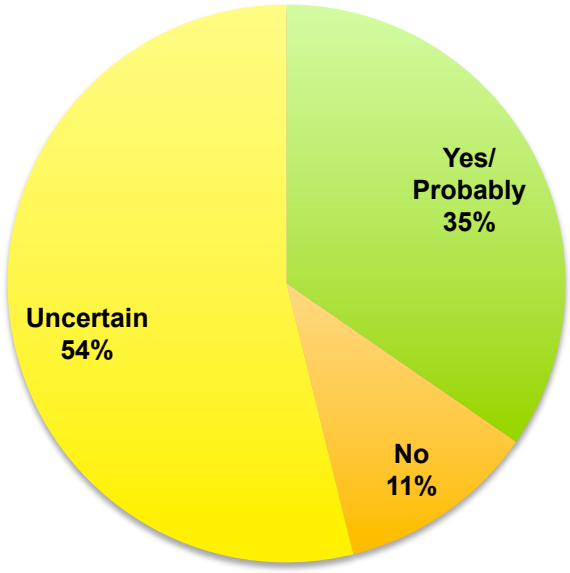


Figure 20: Probablity of Reoccurence



Appendix

C

National Registry of Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

NREMT Initial Certification Fees effective January 1, 2017

The NREMT will be increasing the initial certification fees effective January 1, 2017. The NREMT Board of Directors approved the fee increase effective 2017 following a ten-year price freeze (2007 -2017). The 2017 fee increase reflects the renewed relationship between the NREMT and Pearson VUE. The fee increase is as follows:

NREMT Initial Certification Fees effective January 1, 2017

NREMT Level	Current Fees	Fees Effective 1/1/17	Change
EMR	$65	$75	$10
EMT	$70	$80	$10
AEMT	$100	$115	$15
Intermediate/99	$100	$125	$25
Paramedic	$110	$125	$15

If you have any questions please contact the NREMT at 614-888-4484.

Appendix

D

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
Blue Ridge EMS Council	**33**	**858**	**1**	**185**	**124**	**262**	**1463**
BLUE RIDGE	**33**	**858**	**1**	**185**	**124**	**262**	**1463**
AMHERST	14	133	0	9	8	35	199
Affiliated with Inactive Agency	0	4	0	0	1	1	6
AMHERST CO DEPT OF PUBLIC SAFETY	2	21	0	5	4	19	51
AMHERST LIFE SAVING & FIRST AID CREW	0	23	0	2	0	7	32
CENTRAL VIRGINIA TRAINING CENTER	0	7	0	1	0	0	8
GREIF BROS CORP - RIVERVILLE MILL EMS	0	8	0	0	0	1	9
MONELISON VOLUNTEER RESCUE SQUAD	0	13	0	1	3	4	21
Non-affiliated	12	40	0	0	0	1	53
Not currently affiliated	0	17	0	0	0	2	19
APPOMATTOX	1	67	1	16	10	23	118
APPOMATTOX VOLUNTEER RESCUE SQUAD	0	22	0	6	4	7	39
DELTA RESPONSE TEAM, LLC	0	13	0	3	4	12	32
Non-affiliated	1	8	0	0	0	0	9
Not currently affiliated	0	23	0	1	1	1	26
PAMPLIN VOLUNTEER FIRE DEPARTMENT & EMS INC	0	1	1	6	1	3	12
BEDFORD CITY	0	12	0	7	3	4	26
BEDFORD LIFE SAVING & FIRST AID CREW INC	0	8	0	6	3	4	21
Non-affiliated	0	1	0	0	0	0	1
Not currently affiliated	0	3	0	1	0	0	4
BEDFORD COUNTY	7	209	0	69	20	45	350
Affiliated with Inactive Agency	0	6	0	1	1	0	8
BEDFORD CO DEPARTMENT OF FIRE AND RESCUE	1	33	0	16	6	20	76
BIG ISLAND EMERGENCY CREW INC	1	5	0	3	1	0	10
BOONSBORO VOLUNTEER FIRE & RESCUE	0	5	0	4	1	1	11
CHAMBLISSBURG FIRST AID & RESCUE SQUAD, INC.	0	5	0	2	0	1	8
GOODE VOLUNTEER RESCUE SQUAD	0	9	0	6	3	3	21
HARDY LIFESAVING & RESCUE INC	0	7	0	4	0	2	13

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
HUDDLESTON LIFE SAVING & FIRST AID CREW INC	0	12	0	5	1	1	19
MONETA RESCUE SQUAD, INC.	0	8	0	4	2	3	17
MONTVALE RESCUE SQUAD	0	7	0	5	0	1	13
Non-affiliated	4	44	0	4	1	1	54
Not currently affiliated	0	44	0	11	2	6	63
SHADY GROVE FIRE & RESCUE	0	13	0	0	1	0	14
SMITH MOUNTAIN LAKE MARINE VOLUNTEER FIRE/RESCUE COMPANY	1	2	0	1	0	1	5
STEWARTSVILLE FIRST AID & RESCUE SQUAD	0	9	0	3	1	5	18
CAMPBELL	7	178	0	37	35	32	289
Affiliated with Inactive Agency	0	10	0	2	1	2	15
ALTAVISTA EMS	0	7	0	2	6	2	17
BROOKVILLE-TIMBERLAKE VOLUNTEER FIRE DEPARTMENT	1	3	0	0	0	0	4
CAMPBELL COUNTY PUBLIC SAFETY	0	19	0	5	6	14	44
CAMPBELL COUNTY RESCUE SQUAD	0	20	0	6	7	3	36
CITIZENS EMERGENCY CREW	0	11	0	1	1	3	16
CONCORD RESCUE SQUAD	0	18	0	7	6	2	33
EVINGTON VOLUNTEER FIRE DEPARTMENT	0	6	0	0	0	1	7
Non-affiliated	6	38	0	4	1	0	49
Not currently affiliated	0	27	0	2	4	3	36
RUSTBURG RESCUE SQUAD	0	11	0	6	3	2	22
VIRGINIA AMBULANCE SERVICE, INC.	0	8	0	2	0	0	10
LYNCHBURG	4	259	0	47	48	123	481
Affiliated with Inactive Agency	0	8	0	3	3	8	22
BABCOCK & WILCOX EMERGENCY TEAM	0	24	0	2	1	3	30
CENTRA HEALTH INC	0	33	0	14	14	43	104
LIBERTY UNIVERSITY EMERGENCY SERVICES	0	3	0	0	1	0	4
LYNCHBURG COLLEGE EMERGENCY MEDICAL SERVICES	0	5	0	0	2	1	8

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
LYNCHBURG FIRE DEPARTMENT	0	80	0	19	22	64	185
Non-affiliated	4	77	0	6	5	2	94
Not currently affiliated	0	15	0	2	0	2	19
R R DONNELLEY PRINTING CO.	0	14	0	1	0	0	15
Central Shenandoah EMS Council	**105**	**1576**	**16**	**239**	**249**	**200**	**2385**
CENTRAL SHENANDOAH	**105**	**1576**	**16**	**239**	**249**	**200**	**2385**
AUGUSTA	40	405	8	42	44	31	570
Affiliated with Inactive Agency	3	14	0	1	0	0	18
AUGUSTA COUNTY FIRE & RESCUE	2	72	3	19	17	14	127
AUGUSTA HEALTH TRANSPORTATION SERVICES	0	8	0	0	9	3	20
CHURCHVILLE VOLUNTEER FIRE DEPARTMENT	1	28	1	3	2	0	35
CRAIGSVILLE VOLUNTEER FIRE DEPARTMENT	7	5	0	0	0	0	12
DEERFIELD VALLEY FIRE DEPARTMENT & RESCUE SQUAD	1	9	0	1	0	1	12
DOOMS VOLUNTEER FIRE DEPARTMENT	2	13	0	1	0	0	16
MIDDLEBROOK VOLUNTEER FIRE DEPARTMENT	0	9	0	0	0	0	9
MOUNT SOLON VOLUNTEER FIRE COMPANY/RESCUE SQUAD INC	1	18	0	4	1	0	24
NEW HOPE VOLUNTEER FIRE DEPARTMENT	0	7	0	1	0	3	11
Non-affiliated	15	38	0	0	0	0	53
Not currently affiliated	6	48	0	3	3	1	61
RIVERHEADS VOLUNTEER FIRE DEPT., INC.	0	13	0	1	3	1	18
SHENANDOAH VALLEY REGIONAL AIRPORT ARFF DEPARTMENT	0	11	0	1	1	1	14
STUARTS DRAFT RESCUE SQUAD	1	49	3	3	4	3	63
SWOOPE VOLUNTEER FIRE COMPANY	0	13	0	1	0	0	14
VERONA VOLUNTEER FIRE COMPANY	1	21	0	2	3	0	27
WEYERS CAVE VOLUNTEER FIRE COMPANY	0	29	1	1	1	4	36
BATH	11	42	0	12	10	7	82
Affiliated with Inactive Agency	0	1	0	0	0	0	1

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
BATH COMMUNITY AMBULANCE SERVICE	0	2	0	3	4	4	13
BATH HIGHLAND VOLUNTEER FIRE DEPARTMENT	0	4	0	3	1	0	8
HOT SPRINGS RESCUE SQUAD	5	15	0	6	4	1	31
MILLBORO AREA RESCUE SQUAD	1	7	0	0	1	2	11
Non-affiliated	3	7	0	0	0	0	10
Not currently affiliated	2	6	0	0	0	0	8
BUENA VISTA	10	75	0	9	6	4	104
BUENA VISTA FIREFIGHTERS INC.	7	14	0	3	0	2	26
BUENA VISTA RESCUE SQUAD	2	45	0	6	6	2	61
Non-affiliated	0	10	0	0	0	0	10
Not currently affiliated	1	6	0	0	0	0	7
HARRISONBURG	7	245	4	49	70	50	425
Affiliated with Inactive Agency	0	3	0	1	2	0	6
CITY OF HARRISONBURG FIRE DEPARTMENT	0	52	0	10	15	7	84
HARRISONBURG RESCUE SQUAD	0	61	2	16	24	22	125
Non-affiliated	2	28	0	0	0	0	30
Not currently affiliated	4	18	0	0	0	0	22
ROCKINGHAM COUNTY FIRE/RESCUE	1	83	2	22	29	21	158
HIGHLAND	0	16	0	2	3	4	25
HIGHLAND COUNTY VOLUNTEER RESCUE SQUAD	0	16	0	2	3	4	25
LEXINGTON	1	55	1	3	11	7	78
Affiliated with Inactive Agency	0	8	0	0	3	3	14
LEXINGTON FIRE DEPARTMENT	1	31	1	3	8	4	48
Non-affiliated	0	12	0	0	0	0	12
Not currently affiliated	0	4	0	0	0	0	4
ROCKBRIDGE	14	116	0	30	13	17	190
EFFINGER VOLUNTEER FIRE DEPARTMENT	0	14	0	3	0	0	17
FAIRFIELD VOLUNTEER RESCUE SQUAD	0	16	0	10	3	2	31
GLASGOW LIFE SAVING & FIRST AID CREW INC	0	8	0	6	3	4	21

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
GOSHEN FIRST AID CREW	0	12	0	2	0	0	14
KERR'S CREEK VOLUNTEER FIRE DEPARTMENT	1	5	0	0	1	0	7
NATURAL BRIDGE VOLUNTEER FIRE DEPARTMENT	2	2	0	0	0	0	4
Non-affiliated	0	12	0	0	0	1	13
Not currently affiliated	1	7	0	1	0	0	9
RAPHINE VOLUNTEER FIRE COMPANY INC	2	9	0	5	0	0	16
ROCKBRIDGE BATHS VOLUNTEER FIRE DEPARTMENT	1	9	0	0	0	0	10
ROCKBRIDGE COUNTY FIRE & RESCUE	0	2	0	2	1	10	15
SOUTH RIVER DISTRICT VOLUNTEER FIRE DEPARTMENT	1	13	0	0	4	0	18
WALKERS CREEK VOLUNTEER FIRE DEPARTMENT	6	7	0	1	1	0	15
ROCKINGHAM	16	429	1	65	45	38	594
Affiliated with Inactive Agency	0	25	0	2	5	5	37
BERGTON VOLUNTEER FIRE COMPANY	2	3	0	0	0	0	5
BRIDGEWATER VOLUNTEER RESCUE SQUAD	0	57	0	6	6	2	71
BROADWAY EMERGENCY SQUAD	1	52	0	9	2	3	67
CLOVER HILL VOLUNTEER FIRE COMPANY	1	37	1	11	1	5	56
ELKTON EMERGENCY SQUAD	0	23	0	3	4	2	32
ELKTON VOLUNTEER FIRE COMPANY INC	0	10	0	1	2	1	14
G & W AMBULANCE INC	0	26	0	5	3	2	36
GROTTOES RESCUE SQUAD	0	22	0	11	3	3	39
GROTTOES VOLUNTEER FIRE DEPARTMENT	0	16	0	1	5	4	26
MCGAHEYSVILLE VOLUNTEER FIRE COMPANY	0	13	0	0	1	1	15
MERCK MANUFACTURING DIVISION - STONEWALL	0	9	0	1	1	2	13
MILLER/COORS, LLC	0	5	0	3	1	2	11
Non-affiliated	5	27	0	0	0	0	32
Not currently affiliated	6	39	0	1	0	2	48
PRIORITY PATIENT TRANSPORT, INC.	0	30	0	5	7	4	46
SINGERS GLEN VOLUNTEER FIRE COMPANY	0	7	0	2	1	0	10
SINGERS GLEN VOLUNTEER RESCUE SQUAD	1	17	0	4	2	0	24

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
TIMBERVILLE VOLUNTEER FIRE DEPARTMENT	0	11	0	0	1	0	12
STAUNTON	4	83	1	13	32	21	154
CITY OF STAUNTON FIRE DEPARTMENT	0	27	0	7	8	4	46
Non-affiliated	4	7	0	0	0	0	11
Not currently affiliated	0	14	0	0	0	0	14
STAUNTON-AUGUSTA RESCUE SQUAD	0	35	1	6	24	17	83
WAYNESBORO	2	110	1	14	15	21	163
CITY OF WAYNESBORO FIRE DEPARTMENT	0	36	0	4	3	4	47
INVISTA	1	8	0	0	0	0	9
Non-affiliated	1	7	0	0	0	0	8
Not currently affiliated	0	14	0	0	0	0	14
WAYNESBORO FIRST AID CREW	0	45	1	10	12	17	85
Lord Fairfax EMS Council	**21**	**820**	**2**	**153**	**156**	**238**	**1390**
LORD FAIRFAX	**21**	**820**	**2**	**153**	**156**	**238**	**1390**
CLARKE	1	74	0	10	14	20	119
Affiliated with Inactive Agency	0	6	0	1	1	2	10
BLUE RIDGE VOLUNTEER FIRE COMPANY	0	7	0	0	1	1	9
BOYCE VOLUNTEER FIRE COMPANY	0	11	0	4	2	2	19
CLARKE COUNTY EMERGENCY SERVICES	1	23	0	0	6	13	43
JOHN H. ENDERS VOLUNTEER FIRE & RESCUE SQUAD COMPANY	0	14	0	5	4	1	24
Non-affiliated	0	4	0	0	0	0	4
Not currently affiliated	0	9	0	0	0	1	10
FREDERICK	0	257	0	46	57	122	482
Affiliated with Inactive Agency	0	1	0	0	0	0	1
CLEAR BROOK VOLUNTEER FIRE & RESCUE INC.	0	14	0	1	2	4	21
FREDERICK COUNTY FIRE & RESCUE DEPARTMENT	0	30	0	26	24	32	112
GAINESBORO VOLUNTEER FIRE AND RESCUE COMPANY	0	22	0	1	2	9	34
GORE VOLUNTEER FIRE AND RESCUE	0	7	0	1	0	1	9

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
GREENWOOD VOLUNTEER FIRE & RESCUE COMPANY INC	0	18	0	2	3	2	25
MIDDLETOWN VOLUNTEER FIRE/RESCUE	0	13	0	1	1	5	20
MILLWOOD STATION VOLUNTEER FIRE & RESCUE COMPANY 21 INC	0	12	0	1	3	4	20
Non-affiliated	0	23	0	0	0	0	23
NORTH MOUNTAIN VOLUNTEER FIRE & RESCUE	0	12	0	3	4	3	22
Not currently affiliated	0	18	0	0	0	3	21
REYNOLDS STORE FIRE COMPANY	0	9	0	1	0	2	12
ROUND HILL COMMUNITY FIRE & RESCUE CO., INC.	0	13	0	0	2	1	16
STAR TANNERY VOLUNTEER FIRE DEPARTMENT	0	6	0	2	0	1	9
STEPHENS CITY VOLUNTEER FIRE & RESCUE COMPANY	0	15	0	0	2	3	20
VALLEY MEDICAL TRANSPORT	0	44	0	7	14	52	117
PAGE	0	125	1	30	20	32	208
Affiliated with Inactive Agency	0	3	0	0	1	0	4
LURAY VOLUNTEER RESCUE SQUAD	0	27	0	7	3	4	41
Non-affiliated	0	7	0	0	0	0	7
Not currently affiliated	0	14	0	0	0	1	15
PAGE COUNTY FIRE - EMS	0	11	0	8	6	2	27
SHENANDOAH RESCUE SQUAD	0	9	0	1	5	0	15
STANLEY VOLUNTEER FIRE DEPARTMENT	0	6	0	4	0	0	10
STANLEY VOLUNTEER RESCUE SQUAD	0	13	0	5	1	0	19
VIRGINIA STATE POLICE - TACTICAL EMERGENCY MEDICAL SUPPORT	0	35	1	5	4	25	70
SHENANDOAH	2	196	1	39	30	26	294
Affiliated with Inactive Agency	0	0	0	2	3	0	5
CONICVILLE VOLUNTEER FIRE DEPARTMENT	0	10	0	4	2	1	17
FORT VALLEY VOLUNTEER FIRE DEPARTMENT	0	18	0	3	3	0	24
MOUNT JACKSON RESCUE & FIRE DEPARTMENT, INC.	0	16	0	0	0	3	19

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
NEW MARKET FIRE AND RESCUE DEPARTMENT	0	5	0	0	1	0	6
Non-affiliated	2	10	0	0	0	0	12
Not currently affiliated	0	10	0	3	0	0	13
ORKNEY SPRINGS FIRE & RESCUE, INC.	0	11	0	2	0	0	13
SHENANDOAH COUNTY FIRE AND RESCUE	0	81	1	17	18	17	134
STRASBURG VOLUNTEER RESCUE SQUAD	0	25	0	1	1	3	30
WOODSTOCK VOLUNTEER RESCUE SQUAD	0	10	0	7	2	2	21
WARREN	18	102	0	17	20	16	173
Affiliated with Inactive Agency	0	8	0	2	1	1	12
FRONT ROYAL VOLUNTEER FIRE DEPARTMENT	1	13	0	5	6	4	29
Non-affiliated	2	16	0	0	0	0	18
Not currently affiliated	0	6	0	0	0	1	7
RIVERMONT VOLUNTEER FIRE DEPARTMENT	0	10	0	2	1	0	13
WARREN COUNTY DEPARTMENT OF FIRE & RESCUE SERVICES	15	49	0	8	12	10	94
WINCHESTER	0	66	0	11	15	22	114
Non-affiliated	0	9	0	0	0	0	9
Not currently affiliated	0	6	0	0	2	0	8
WINCHESTER FIRE & RESCUE DEPARTMENT	0	51	0	11	13	22	97
Non-Affiliated	**0**	**3**	**0**	**0**	**0**	**0**	**3**
NON-AFFILIATED	**0**	**3**	**0**	**0**	**0**	**0**	**3**
NON-AFFILIATED	0	3	0	0	0	0	3
Non-affiliated	0	2	0	0	0	0	2
Not currently affiliated	0	1	0	0	0	0	1
Northern Virginia EMS Council	**170**	**4927**	**1**	**42**	**544**	**1224**	**6908**
NORTHERN VIRGINIA	**170**	**4927**	**1**	**42**	**544**	**1224**	**6908**
ALEXANDRIA	6	267	0	4	23	82	382
ALEXANDRIA FIRE DIVISION - EMS	2	173	0	3	19	70	267
Non-affiliated	3	77	0	1	0	7	88

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
Not currently affiliated	1	17	0	0	4	5	27
ARLINGTON	0	377	0	0	32	95	504
Affiliated with Inactive Agency	0	0	0	0	0	1	1
ARLINGTON COUNTY FIRE DEPT	0	218	0	0	31	84	333
Non-affiliated	0	132	0	0	0	5	137
Not currently affiliated	0	27	0	0	1	5	33
FAIRFAX	1	159	0	3	47	77	287
CITY OF FAIRFAX FIRE DEPARTMENT	0	62	0	0	13	40	115
Non-affiliated	0	24	0	0	5	3	32
Not currently affiliated	0	3	0	0	1	1	5
PHYSICIANS TRANSPORT SERVICE	1	70	0	3	28	33	135
FAIRFAX COUNTY	14	1945	1	9	190	494	2653
Affiliated with Inactive Agency	0	3	0	0	0	2	5
FAIRFAX COUNTY FIRE & RESCUE	0	1160	0	6	146	402	1714
FAIRFAX COUNTY POLICE DEPARTMENT	0	14	0	0	0	15	29
FORT BELVIOR COMMUNITY HOSPITAL EMS	0	1	0	0	0	19	20
FORT BELVOIR FIRE DEPARTMENT	0	65	0	1	20	8	94
Non-affiliated	14	592	1	0	15	20	642
Not currently affiliated	0	110	0	2	9	28	149
FALLS CHURCH	0	15	0	0	0	3	18
Affiliated with Inactive Agency	0	1	0	0	0	3	4
Non-affiliated	0	11	0	0	0	0	11
Not currently affiliated	0	3	0	0	0	0	3
LOUDOUN	138	949	0	21	105	194	1407
Affiliated with Inactive Agency	0	9	0	0	4	9	22
ALDIE VOLUNTEER FIRE COMPANY INC	5	3	0	0	0	0	8
ARCOLA-PLEASANT VALLEY FIRE DEPARTMENT	6	32	0	2	7	3	50
ASHBURN VOLUNTEER FIRE AND RESCUE DEPARTMENT	12	67	0	1	6	3	89
HAMILTON VOLUNTEER FIRE DEPARTMENT	0	4	0	0	2	0	6

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
HAMILTON VOLUNTEER RESCUE SQUAD	1	20	0	0	0	1	22
LEESBURG VOLUNTEER FIRE COMPANY, INC.	19	25	0	0	2	1	47
LOUDOUN COUNTY FIRE AND RESCUE	1	343	0	0	39	51	434
LOUDOUN COUNTY VOLUNTEER RESCUE SQUAD	0	54	0	3	12	15	84
LOVETTSVILLE DISTRICT FIRE & RESCUE	12	15	0	1	0	1	29
Non-affiliated	19	103	0	0	0	2	124
Not currently affiliated	8	53	0	0	4	1	66
PHI AIR MEDICAL, LLC	0	4	0	0	1	56	61
PHILOMONT VOLUNTEER FIRE COMPANY	1	7	0	0	0	2	10
PURCELLVILLE VOLUNTEER FIRE DEPARTMENT	17	21	0	0	0	0	38
PURCELLVILLE VOLUNTEER RESCUE SQUAD, INC.	0	41	0	7	4	9	61
ROUND HILL VOLUNTEER FIRE DEPARTMENT & RESCUE	1	6	0	0	1	0	8
STERLING VOLUNTEER FIRE DEPARTMENT	36	54	0	2	7	7	106
STERLING VOLUNTEER RESCUE SQUAD	0	88	0	5	16	33	142
MANASSAS	5	111	0	0	22	19	157
Affiliated with Inactive Agency	0	13	0	0	1	0	14
CITY OF MANASSAS FIRE AND RESCUE	0	29	0	0	14	10	53
GREATER MANASSAS VOLUNTEER RESCUE SQUAD	0	27	0	0	5	3	35
MANASSAS VOLUNTEER FIRE COMPANY, INC.	1	9	0	0	2	2	14
Non-affiliated	1	18	0	0	0	2	21
Not currently affiliated	0	14	0	0	0	0	14
VIRGINIA AIRBORNE SEARCH & RESCUE SQUAD	3	1	0	0	0	2	6
MANASSAS PARK	0	18	0	1	5	9	33
CITY OF MANASSAS PARK FIRE DEPARTMENT	0	9	0	1	5	8	23
Non-affiliated	0	6	0	0	0	1	7
Not currently affiliated	0	3	0	0	0	0	3
PRINCE WILLIAM	6	1086	0	4	120	251	1467
AEROMEDICAL TRANSPORT SPECIALISTS INC	0	1	0	0	0	1	2
Affiliated with Inactive Agency	0	21	0	0	1	1	23

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
BUCKHALL VOLUNTEER FIRE & RESCUE	0	23	0	2	2	0	27
DALE CITY VOLUNTEER FIRE DEPARTMENT	0	90	0	1	14	15	120
DUMFRIES-TRIANGLE RESCUE SQUAD	0	22	0	0	1	2	25
DUMFRIES-TRIANGLE VOLUNTEER FIRE DEPARTMENT	0	18	0	0	2	1	21
EVERGREEN VOLUNTEER FIRE/RESCUE	0	16	0	0	2	1	19
LAKE JACKSON VOLUNTEER FIRE DEPARTMENT	0	24	0	0	1	2	27
NOKESVILLE VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD	0	78	0	0	4	6	88
Non-affiliated	5	171	0	1	1	9	187
Not currently affiliated	1	119	0	0	9	12	141
O.W.L. FIRE DEPARTMENT & RESCUE SQUAD	0	102	0	0	13	10	125
PRINCE WILLIAM COUNTY DEPARTMENT OF FIRE & RESCUE	0	319	0	0	59	181	559
STONEWALL JACKSON VOLUNTEER FIRE DEPARTMENT/RESCUE SQUAD	0	42	0	0	7	2	51
T.A.C. PROJECTS, INC.	0	13	0	0	3	8	24
YORKSHIRE VOLUNTEER FIRE DEPARTMENT	0	27	0	0	1	0	28
Old Dominion EMS Alliance	**151**	**4425**	**0**	**200**	**553**	**1387**	**6716**
CRATER	**13**	**557**	**0**	**23**	**157**	**197**	**947**
COLONIAL HEIGHTS	2	34	0	1	18	37	92
COLONIAL HEIGHTS FIRE/EMS	0	14	0	1	18	35	68
Non-affiliated	2	13	0	0	0	1	16
Not currently affiliated	0	7	0	0	0	1	8
DINWIDDIE	5	88	0	2	17	45	157
Affiliated with Inactive Agency	0	1	0	0	3	2	6
AIR METHODS INC. / ROCKY MOUNTAIN HOLDINGS LLC.	0	3	0	0	0	18	21
DINWIDDIE COUNTY FIRE AND EMS	0	45	0	0	11	21	77
GERDAU	0	4	0	0	3	2	9
Non-affiliated	0	16	0	0	0	0	16

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
Not currently affiliated	1	18	0	1	0	1	21
RICHARD BLAND COLLEGE POLICE & EMERGENCY SERVICES	4	1	0	1	0	1	7
EMPORIA	0	46	0	5	25	24	100
GREENSVILLE VOLUNTEER RESCUE SQUAD	0	18	0	4	5	4	31
LIFESTAR AMBULANCE SERVICE, INC.	0	21	0	1	18	19	59
Non-affiliated	0	2	0	0	0	0	2
Not currently affiliated	0	5	0	0	2	1	8
GREENSVILLE	0	5	0	1	1	0	7
Not currently affiliated	0	5	0	1	1	0	7
HOPEWELL	4	94	0	0	26	20	144
Affiliated with Inactive Agency	0	3	0	0	3	3	9
HERCULES INC	3	12	0	0	0	0	15
HONEYWELL RESINS & CHEMICALS LLC	0	30	0	0	0	0	30
HOPEWELL BUREAU OF FIRE	0	22	0	0	16	5	43
HOPEWELL EMERGENCY CREW	0	14	0	0	7	10	31
Non-affiliated	1	5	0	0	0	0	6
Not currently affiliated	0	8	0	0	0	2	10
PETERSBURG	0	107	0	3	20	33	163
Affiliated with Inactive Agency	0	4	0	0	1	1	6
Non-affiliated	0	5	0	0	0	0	5
Not currently affiliated	0	6	0	0	0	0	6
PETERSBURG FIRE DEPARTMENT	0	59	0	3	7	10	79
SOUTHSIDE VIRGINIA EMERGENCY CREW	0	33	0	0	12	22	67
PRINCE GEORGE	1	112	0	6	39	31	189
FORT LEE FIRE AND EMERGENCY SERVICES	0	21	0	2	18	7	48
Non-affiliated	1	20	0	0	0	1	22
Not currently affiliated	0	18	0	0	1	1	20
PRINCE GEORGE FIRE AND EMS	0	53	0	4	20	22	99

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SURRY	1	56	0	0	6	4	67
Non-affiliated	1	4	0	0	0	0	5
Not currently affiliated	0	1	0	0	0	0	1
SURRY NUCLEAR POWER STATION	0	35	0	0	1	1	37
SURRY VOLUNTEER RESCUE SQUAD	0	16	0	0	5	3	24
SUSSEX	0	15	0	5	5	3	28
JARRATT VOLUNTEER FIRE DEPARTMENT	0	8	0	0	4	1	13
Non-affiliated	0	1	0	0	0	0	1
Not currently affiliated	0	1	0	0	0	0	1
STONY CREEK RESCUE SQUAD	0	2	0	4	1	0	7
WAVERLY RESCUE SQUAD	0	3	0	1	0	2	6
METRO RICHMOND	**107**	**3247**	**0**	**73**	**293**	**1002**	**4722**
CHARLES CITY	0	22	0	0	0	1	23
CHARLES CITY COUNTY VOLUNTEER FIRE DEPARTMENT	0	15	0	0	0	1	16
Non-affiliated	0	4	0	0	0	0	4
Not currently affiliated	0	3	0	0	0	0	3
CHESTERFIELD	62	892	0	12	78	300	1344
BENSLEY-BERMUDA VOLUNTEER RESCUE SQUAD	0	25	0	0	2	6	33
CHESTERFIELD FIRE AND EMS	42	383	0	5	57	231	718
DEFENSE SUPPLY CENTER RICHMOND	0	14	0	1	1	11	27
DUPONT (E I DUPONT MERT) - CHESTERFIELD	0	36	0	0	0	0	36
DUPONT TEIJIN FILMS - HOPEWELL	0	26	0	0	0	1	27
ETTRICK-MATOACA VOLUNTEER RESCUE SQUAD	0	7	0	2	1	2	12
FOREST VIEW VOLUNTEER RESCUE SQUAD	0	39	0	0	7	19	65
HONEYWELL INTERNATIONAL	0	22	0	0	0	0	22
MANCHESTER VOLUNTEER RESCUE SQUAD	0	26	0	1	2	11	40
Non-affiliated	18	208	0	0	2	6	234
Not currently affiliated	2	103	0	2	6	9	122
PRIORITY 1 AMBULANCE SERVICES LLC	0	3	0	1	0	0	4

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
VIRGINIA STATE POLICE - MEDFLIGHT I	0	0	0	0	0	4	4
GOOCHLAND	0	142	0	3	16	38	199
GOOCHLAND COUNTY DEPARTMENT OF FIRE-RESCUE AND EMERGENCY SERVICES	0	114	0	3	16	36	169
Non-affiliated	0	13	0	0	0	0	13
Not currently affiliated	0	15	0	0	0	2	17
HANOVER	2	500	0	21	44	160	727
Affiliated with Inactive Agency	0	16	0	0	1	5	22
ASHLAND VOLUNTEER RESCUE SQUAD	0	32	0	4	1	9	46
EAST HANOVER VOLUNTEER RESCUE SQUAD INC	0	37	0	1	6	9	53
EMERGENCY TRAINING SYSTEMS, INC.	0	8	0	0	4	11	23
HANOVER FIRE EMS	0	265	0	7	20	103	395
KINGS DOMINION	0	2	0	1	2	1	6
Non-affiliated	1	82	0	1	0	2	86
Not currently affiliated	1	25	0	1	1	10	38
VIRGINIA DRAGWAY, INC.	0	4	0	0	3	0	7
WEST HANOVER VOLUNTEER RESCUE SQUAD, INC.	0	29	0	6	6	10	51
HENRICO	8	763	0	20	122	285	1198
Affiliated with Inactive Agency	0	2	0	0	0	1	3
AMELIA AMBULANCE SERVICE	0	10	0	0	5	8	23
DELTA MEDICAL TRANSPORT	0	8	0	0	0	3	11
FORREST AMBULANCE SERVICE	0	19	0	0	5	15	39
HENRICO COUNTY DIVISION OF FIRE	5	354	0	12	78	185	634
HENRICO VOLUNTEER RESCUE SQUAD	0	34	0	2	9	9	54
LAKESIDE VOLUNTEER RESCUE SQUAD	0	35	0	1	4	16	56
Non-affiliated	1	137	0	0	1	3	142
Not currently affiliated	2	86	0	1	2	11	102
RICHMOND INTERNATIONAL AIRPORT FIRE DEPARTMENT	0	15	0	1	0	2	18

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
RICHMOND INTERNATIONAL RACEWAY	0	12	0	1	2	9	24
TUCKAHOE VOLUNTEER RESCUE SQUAD	0	51	0	2	16	23	92
NEW KENT	4	92	0	6	6	17	125
NEW KENT FIRE-RESCUE	0	40	0	5	2	11	58
Non-affiliated	3	16	0	0	0	1	20
Not currently affiliated	1	2	0	0	0	1	4
PROVIDENCE FORGE VOLUNTEER RESCUE SQUAD	0	34	0	1	4	4	43
POWHATAN	4	101	0	3	3	14	125
Non-affiliated	3	25	0	0	0	0	28
Not currently affiliated	1	18	0	0	0	3	22
POWHATAN COUNTY FIRE DEPARTMENT	0	31	0	1	2	5	39
POWHATAN VOLUNTEER RESCUE SQUAD	0	27	0	2	1	6	36
RICHMOND CITY	27	735	0	8	24	187	981
Affiliated with Inactive Agency	0	2	0	0	0	3	5
CITY OF RICHMOND DEPARTMENT OF FIRE & EMERGENCY SERVICES	0	374	0	2	12	25	413
Non-affiliated	1	150	0	0	0	7	158
Not currently affiliated	1	66	0	1	1	15	84
PHILIP MORRIS USA	25	17	0	0	0	0	42
RICHMOND AMBULANCE AUTHORITY	0	107	0	5	10	118	240
RICHMOND VOLUNTEER RESCUE SQUAD	0	19	0	0	1	19	39
SOUTH CENTRAL	**5**	**336**	**0**	**87**	**51**	**91**	**570**
AMELIA	1	42	0	9	11	9	72
AMELIA COUNTY VOLUNTEER FIRE DEPARTMENT	0	19	0	5	5	6	35
AMELIA EMERGENCY SQUAD	0	10	0	4	6	3	23
Non-affiliated	1	9	0	0	0	0	10
Not currently affiliated	0	4	0	0	0	0	4
BUCKINGHAM	0	42	0	11	3	4	60
Affiliated with Inactive Agency	0	0	0	1	0	0	1

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
ALLENS AMBULANCE SERVICE	0	4	0	0	0	0	4
BUCKINGHAM COUNTY VOLUNTEER RESCUE SQUAD	0	24	0	10	3	4	41
Non-affiliated	0	11	0	0	0	0	11
Not currently affiliated	0	3	0	0	0	0	3
CHARLOTTE	2	37	0	10	7	14	70
CHARLOTTE COUNTY FIRE & RESCUE ASSOCIATION	0	6	0	0	1	1	8
CHARLOTTE COUNTY VOLUNTEER RESCUE SQUAD	1	14	0	10	5	8	38
CHARLOTTE COURTHOUSE VOL FIRE DEPT	1	5	0	0	1	3	10
DRAKES BRANCH VOLUNTEER FIRE DEPARTMENT INC.	0	5	0	0	0	2	7
Non-affiliated	0	3	0	0	0	0	3
Not currently affiliated	0	4	0	0	0	0	4
CUMBERLAND	0	40	0	8	1	3	52
Affiliated with Inactive Agency	0	1	0	0	0	0	1
CARTERSVILLE VOLUNTEER RESCUE SQUAD INC	0	14	0	4	1	0	19
CUMBERLAND VOLUNTEER RESCUE SQUAD	0	9	0	3	0	3	15
Non-affiliated	0	11	0	1	0	0	12
Not currently affiliated	0	5	0	0	0	0	5
LUNENBURG	0	59	0	10	11	18	98
KENBRIDGE EMERGENCY SQUAD	0	11	0	2	4	4	21
MEHERRIN VOLUNTEER FIRE & RESCUE, INC.	0	12	0	6	2	4	24
Non-affiliated	0	9	0	0	0	0	9
Not currently affiliated	0	6	0	0	0	0	6
VICTORIA FIRE & RESCUE	0	21	0	2	5	10	38
NOTTOWAY	2	69	0	11	15	18	115
BLACKSTONE FIRE DEPARTMENT	0	11	0	0	2	0	13
BURKEVILLE VOLUNTEER FIRE DEPARTMENT	0	7	0	1	4	2	14
CREWE VOLUNTEER FIRE DEPARTMENT	1	4	0	3	0	1	9
FORT PICKETT FIRE DEPARTMENT	0	13	0	2	6	6	27
Non-affiliated	1	8	0	0	0	0	9

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
Not currently affiliated	0	2	0	0	0	0	2
NOTTOWAY COUNTY EMERGENCY SQUAD	0	24	0	5	3	9	41
PRINCE EDWARD	0	47	0	28	3	25	103
Affiliated with Inactive Agency	0	3	0	1	1	6	11
HAMPDEN-SYDNEY VOLUNTEER FIRE DEPARTMENT INC	0	2	0	2	0	3	7
Non-affiliated	0	4	0	1	0	0	5
Not currently affiliated	0	8	0	0	0	0	8
PALADIN MEDICAL TRANSPORT	0	0	0	1	0	1	2
PRINCE EDWARD VOLUNTEER RESCUE SQUAD	0	30	0	23	2	15	70
SOUTHSIDE	**26**	**285**	**0**	**17**	**52**	**97**	**477**
BRUNSWICK	4	36	0	2	5	16	63
Affiliated with Inactive Agency	0	7	0	0	0	1	8
ALBERTA FIRE DEPARTMENT INC.	0	5	0	0	2	1	8
BRUNSWICK COUNTY SHERIFF'S OFFICE	0	0	0	1	0	3	4
BRUNSWICK VOLUNTEER RESCUE SQUAD	0	9	0	0	1	4	14
CENTRAL LIFE SAVING & RESCUE SQUAD	0	4	0	1	1	6	12
Non-affiliated	4	3	0	0	0	0	7
Not currently affiliated	0	8	0	0	1	1	10
HALIFAX	18	151	0	12	24	47	252
Affiliated with Inactive Agency	0	9	0	0	1	7	17
CLOVER POWER STATION & VA ELECTRIC AND POWER CO.	0	10	0	0	1	3	14
HALIFAX COUNTY FIRE COMMISSION	12	61	0	5	4	9	91
HALIFAX COUNTY RESCUE SQUAD	0	24	0	3	8	21	56
Non-affiliated	6	15	0	0	0	0	21
NORTH HALIFAX VOLUNTEER FIRE DEPARTMENT	0	9	0	2	4	1	16
Not currently affiliated	0	5	0	0	0	0	5
PATIENT TRANSPORT SYSTEMS	0	11	0	1	5	6	23
TURBEVILLE VOLUNTEER FIRE AND RESCUE	0	6	0	0	1	0	7

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
ASSOCIATION INC.							
VIRGINIA INTERNATIONAL RACEWAY	0	1	0	1	0	0	2
MECKLENBURG	4	98	0	3	23	34	162
Affiliated with Inactive Agency	0	2	0	0	3	2	7
AMERICAN LIFELINE MEDICAL TRANSPORT INC	0	7	0	1	1	0	9
BOYDTON LIFE STATION INC	0	10	0	0	2	1	13
CHASE CITY RESCUE SQUAD	0	10	0	0	2	3	15
LAKE GASTON VOLUNTEER FIRE DEPARTMENT	0	8	0	0	0	1	9
MECKLENBURG COUNTY LIFE SAVING & RESCUE SQUAD	2	10	0	2	0	9	23
Non-affiliated	2	18	0	0	0	0	20
Not currently affiliated	0	15	0	0	2	0	17
SOUTHSIDE RESCUE SQUAD	0	18	0	0	13	18	49
Out of State	**27**	**720**	**0**	**29**	**26**	**298**	**1101**
OUT OF STATE	**27**	**720**	**0**	**29**	**26**	**298**	**1101**
OUT OF STATE	27	720	0	29	26	298	1101
Affiliated with Inactive Agency	0	5	0	0	0	5	10
AIR EVAC EMS, INC.	0	0	0	0	0	22	22
AIRCARE	0	1	0	0	0	29	30
AMBULANCE SERVICE OF BRISTOL INC	0	15	0	5	2	13	35
AMERICAN MEDICAL RESPONSE MID-ATLANTIC, INC (NOVA)	0	9	0	0	1	8	18
EAGLEMED LLC	0	1	0	0	0	1	2
MED-TRANS CORPORATION DBA WINGS AIR RESCUE	0	6	0	0	0	41	47
METRO-WASHINGTON AIRPORT AUTHORITY FIRE/RESCUE DEPT	3	100	0	3	4	29	139
MID-ATLANTIC AIR TRANSPORT SERVICE	0	0	0	0	0	20	20
Non-affiliated	23	418	0	8	7	75	532
Not currently affiliated	1	162	0	11	11	54	239
REPUBLIC AMBULANCE SERVICE	0	3	0	2	1	1	7

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
Peninsulas EMS Council	**91**	**1423**	**3**	**91**	**589**	**631**	**2828**
MIDDLE PENINSULA	**9**	**352**	**0**	**34**	**70**	**96**	**561**
ESSEX	1	23	0	6	16	25	71
Affiliated with Inactive Agency	0	11	0	2	5	7	25
ESSEX COUNTY EMS	0	4	0	2	10	14	30
Non-affiliated	1	2	0	0	0	1	4
Not currently affiliated	0	1	0	0	0	0	1
TAPPAHANNOCK-ESSEX VOLUNTEER FIRE DEPARTMENT	0	5	0	2	1	3	11
GLOUCESTER	3	116	0	11	22	30	182
ABINGDON VOLUNTEER FIRE & RESCUE, INC.	0	31	0	2	7	16	56
GLOUCESTER VOLUNTEER FIRE & RESCUE SQUAD, INC.	0	44	0	8	12	12	76
Non-affiliated	3	24	0	0	0	0	27
Not currently affiliated	0	17	0	1	3	2	23
KING AND QUEEN	0	55	0	2	10	8	75
KING & QUEEN COUNTY DEPARTMENT OF EMERGENCY SERVICES	0	2	0	0	4	3	9
KING & QUEEN VOL. RESCUE SQUAD	0	7	0	0	2	1	10
LOWER KING & QUEEN VOLUNTEER FIRE DEPARTMENT	0	13	0	1	2	2	18
MATTAPONI VOLUNTEER RESCUE SQUAD, INC.	0	21	0	1	2	2	26
Non-affiliated	0	9	0	0	0	0	9
Not currently affiliated	0	3	0	0	0	0	3
KING WILLIAM	1	70	0	6	8	12	97
Affiliated with Inactive Agency	0	0	0	0	0	1	1
KING WILLIAM VOLUNTEER FIRE & RESCUE SQUAD	0	20	0	2	1	5	28
MANGOHICK VOLUNTEER FIRE DEPARTMENT	0	12	0	0	0	0	12
Non-affiliated	1	15	0	1	0	0	17
Not currently affiliated	0	6	0	0	0	3	9
WEST POINT VOLUNTEER FIRE DEPARTMENT & RESCUE	0	17	0	3	7	3	30
MATHEWS	1	36	0	1	8	7	53

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
MATHEWS VOLUNTEER RESCUE SQUAD	0	14	0	1	5	7	27
Non-affiliated	1	10	0	0	0	0	11
Not currently affiliated	0	12	0	0	3	0	15
MIDDLESEX	3	52	0	8	6	14	83
CENTRAL MIDDLESEX VOLUNTEER RESCUE SQUAD	0	24	0	3	3	7	37
MIDDLESEX COUNTY VOLUNTEER RESCUE SQUAD, INC.	1	16	0	5	2	7	31
Non-affiliated	2	6	0	0	1	0	9
Not currently affiliated	0	6	0	0	0	0	6
NORTHERN NECK	**13**	**166**	**1**	**31**	**43**	**58**	**312**
LANCASTER	1	24	1	11	9	14	60
KILMARNOCK-LANCASTER VOLUNTEER RESCUE SQUAD	0	7	0	4	0	2	13
LANCASTER COUNTY DEPARTMENT OF EMERGENCY SERVICES	0	8	1	4	8	11	32
Non-affiliated	1	4	0	0	0	1	6
Not currently affiliated	0	4	0	0	0	0	4
UPPER LANCASTER VOLUNTEER RESCUE SQUAD	0	1	0	3	1	0	5
NORTHUMBERLAND	11	41	0	7	6	8	73
CALLAO RESCUE SQUAD INC	0	9	0	0	2	4	15
MID-COUNTY VOLUNTEER RESCUE SQUAD	0	12	0	2	1	0	15
Non-affiliated	11	11	0	0	0	0	22
NORTHUMBERLAND COUNTY RESCUE SQUAD	0	6	0	4	2	4	16
Not currently affiliated	0	3	0	1	1	0	5
RICHMOND COUNTY	1	18	0	0	13	8	40
Affiliated with Inactive Agency	0	0	0	0	1	0	1
Non-affiliated	1	4	0	0	0	0	5
Not currently affiliated	0	5	0	0	0	0	5
RICHMOND COUNTY EMERGENCY MEDICAL SERVICES	0	9	0	0	12	8	29
WESTMORELAND	0	83	0	13	15	28	139
COLONIAL BEACH RESCUE SQUAD	0	13	0	2	1	3	19

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
COLONIAL BEACH VOLUNTEER FIRE DEPARTMENT INC	0	11	0	1	1	0	13
COPLE DISTRICT VOLUNTEER FIRE DEPARTMENT	0	6	0	0	0	0	6
MONTROSS VOLUNTEER RESCUE SQUAD	0	7	0	3	3	8	21
Non-affiliated	0	10	0	0	1	0	11
Not currently affiliated	0	8	0	0	0	0	8
OAK GROVE VOLUNTEER FIRE DEPARTMENT	0	15	0	2	1	1	19
WESTMORELAND COUNTY DEPARTMENT OF EMERGENCY SERVICES	0	3	0	3	7	14	27
WESTMORELAND COUNTY RESCUE SQUAD	0	7	0	0	0	0	7
WESTMORELAND VOLUNTEER FIRE DEPARTMENT	0	3	0	2	1	2	8
VIRGINIA PENINSULA	**69**	**905**	**2**	**26**	**476**	**477**	**1955**
HAMPTON	1	244	2	6	198	137	588
Affiliated with Inactive Agency	0	26	0	0	13	13	52
HAMPTON DIVISION OF FIRE/RESCUE	0	117	2	5	176	113	413
Non-affiliated	1	75	0	0	0	5	81
Not currently affiliated	0	26	0	1	9	6	42
JAMES CITY COUNTY	41	203	0	8	52	83	387
ANHEUSER-BUSCH INC	16	5	0	0	1	0	22
BUSCH GARDENS - WATER COUNTRY USA	0	1	0	0	1	1	3
JAMES CITY COUNTY FIRE DEPARTMENT	0	66	0	4	35	52	157
JAMES CITY RESCUE SQUAD	0	49	0	3	5	7	64
Non-affiliated	14	35	0	0	0	4	53
Not currently affiliated	1	9	0	0	1	6	17
WILLIAMSBURG FIRE DEPARTMENT - EMS	10	38	0	1	9	13	71
NEWPORT NEWS	9	256	0	6	184	171	626
Affiliated with Inactive Agency	0	0	0	0	1	0	1
CARDINAL AMBULANCE SERVICE, INC.	0	1	0	0	1	1	3
EAGLE MEDICAL TRANSPORTS, LLC.	0	27	0	1	5	6	39
FORT EUSTIS/FORT STORY FIRE & EMERGENCY SERVICES	0	26	0	0	6	3	35

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
MCDONALD ARMY HEALTH CENTER	0	4	0	0	2	7	13
NEWPORT NEWS FIRE DEPARTMENT	0	73	0	2	149	126	350
NEWPORT NEWS SHIPBUILDING FIRE DEPARTMENT	0	9	0	1	7	0	17
Non-affiliated	9	88	0	2	0	8	107
Not currently affiliated	0	28	0	0	4	8	40
RIVERSIDE PATIENT TRANSPORT	0	0	0	0	9	12	21
POQUOSON	1	41	0	2	10	13	67
Non-affiliated	0	11	0	0	0	1	12
Not currently affiliated	1	4	0	0	1	1	7
POQUOSON FIRE & RESCUE	0	26	0	2	9	11	48
WILLIAMSBURG	9	34	0	0	1	1	45
EASTERN STATE HOSPITAL	0	6	0	0	0	0	6
Non-affiliated	9	21	0	0	0	1	31
Not currently affiliated	0	7	0	0	1	0	8
YORK	8	127	0	4	31	72	242
CAMP PEARY FIRE AND EMS	0	2	0	0	2	12	16
Non-affiliated	7	47	0	0	1	2	57
Not currently affiliated	1	18	0	0	2	3	24
YORK COUNTY FIRE AND LIFE SAFETY	0	60	0	4	26	55	145
Rappahannock EMS Council	**17**	**1982**	**0**	**143**	**333**	**459**	**2934**
RAPPAHANNOCK	**9**	**1460**	**0**	**51**	**222**	**338**	**2080**
CAROLINE	6	155	0	3	20	52	236
Affiliated with Inactive Agency	4	35	0	0	3	9	51
CAROLINE COUNTY DEPARTMENT OF FIRE AND RESCUE	2	94	0	3	17	39	155
Non-affiliated	0	16	0	0	0	1	17
Not currently affiliated	0	10	0	0	0	3	13
FREDERICKSBURG	1	187	0	7	12	31	238
FREDERICKSBURG FIRE DEPARTMENT	0	40	0	0	4	19	63
FREDERICKSBURG RESCUE SQUAD	0	59	0	6	7	8	80

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
Non-affiliated	1	72	0	0	0	1	74
Not currently affiliated	0	16	0	1	1	3	21
KING GEORGE	1	80	0	10	25	31	147
Affiliated with Inactive Agency	0	2	0	0	0	6	8
KING GEORGE DEPARTMENT OF FIRE,RESCUE AND EMERGENCY SERVICES	0	17	0	4	18	18	57
KING GEORGE FIRE & RESCUE, INC.	1	27	0	4	5	3	40
NAVAL SUPPORT ACTIVITY (NSA) SOUTH POTOMAC DAHLGREN	0	18	0	1	2	2	23
Non-affiliated	0	10	0	0	0	0	10
Not currently affiliated	0	6	0	1	0	2	9
SPOTSYLVANIA	1	411	0	23	71	87	593
Affiliated with Inactive Agency	0	3	0	0	0	0	3
CHANCELLOR VOLUNTEER FIRE & RESCUE DEPARTMENT	1	43	0	4	11	9	68
Non-affiliated	0	81	0	2	2	2	87
Not currently affiliated	0	85	0	1	8	9	103
SPOTSYLVANIA COUNTY FIRE & RESCUE	0	133	0	3	37	46	219
SPOTSYLVANIA VOLUNTEER RESCUE SQUAD INC.	0	66	0	13	13	21	113
STAFFORD	0	627	0	8	94	137	866
Affiliated with Inactive Agency	0	99	0	2	15	17	133
LIFECARE MEDICAL TRANSPORTS INC.	0	19	0	2	12	18	51
Non-affiliated	0	133	0	0	3	10	146
Not currently affiliated	0	31	0	0	3	8	42
QUANTICO FIRE DEPARTMENT	0	61	0	1	3	12	77
ROCKHILL VOLUNTEER RESCUE SQUAD	0	8	0	0	0	2	10
STAFFORD COUNTY FIRE AND RESCUE DEPARTMENT	0	276	0	3	58	70	407
RAPPAHANNOCK-RAPIDAN	**8**	**522**	**0**	**92**	**111**	**121**	**854**
CULPEPER	0	137	0	16	36	26	215
Affiliated with Inactive Agency	0	2	0	0	0	1	3

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BRANDY STATION VOLUNTEER FIRE DEPARTMENT	0	8	0	2	2	0	12
CULPEPER COUNTY OFFICE OF EMERGENCY SERVICES	0	11	0	5	16	2	34
CULPEPER COUNTY RESCUE SQUAD	0	22	0	2	3	5	32
CULPEPER REGIONAL HOSPITAL INC	0	1	0	0	1	4	6
LITTLE FORK VOLUNTEER FIRE & RESCUE COMPANY	0	25	0	3	6	3	37
Non-affiliated	0	14	0	0	0	1	15
Not currently affiliated	0	21	0	1	2	2	26
REVA VOLUNTEER FIRE & RESCUE	0	13	0	2	0	3	18
RICHARDSVILLE VOLUNTEER FIRE DEPARTMENT/RESCUE SQUAD, INC.	0	11	0	1	3	5	20
SALEM VOLUNTEER FIRE DEPARTMENT	0	9	0	0	3	0	12
FAUQUIER	1	211	0	49	51	52	364
Affiliated with Inactive Agency	0	3	0	0	2	9	14
CATLETT VOLUNTEER FIRE & RESCUE COMPANY	0	11	0	1	1	1	14
FAUQUIER COUNTY FIRE - RESCUE	0	9	0	26	22	17	74
GOLDVEIN VOLUNTEER FIRE & RESCUE DEPARTMENT	0	7	0	2	1	1	11
LOIS VOLUNTEER FIRE DEPARTMENT	0	11	0	0	0	0	11
MARSHALL VOLUNTEER FIRE DEPARTMENT	0	1	0	0	0	1	2
MARSHALL VOLUNTEER RESCUE SQUAD	0	7	0	1	0	1	9
NEW BALTIMORE VOLUNTEER FIRE COMPANY	0	21	0	6	5	1	33
Non-affiliated	1	44	0	0	1	1	47
Not currently affiliated	0	20	0	2	4	3	29
ORLEAN VOLUNTEER FIRE COMPANY, INC.	0	10	0	2	1	1	14
REMINGTON VOLUNTEER FIRE & RESCUE DEPARTMENT, INC.	0	30	0	2	1	3	36
THE PLAINS VOLUNTEER FIRE COMPANY	0	4	0	0	0	2	6
UPPERVILLE VOLUNTEER FIRE COMPANY	0	0	0	1	1	0	2
WARRENTON TRAINING FIRE DEPARTMENT	0	4	0	3	9	3	19
WARRENTON VOLUNTEER FIRE COMPANY	0	29	0	3	3	8	43

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
ORANGE	6	95	0	15	16	31	163
Affiliated with Inactive Agency	0	3	0	1	0	1	5
LAKE OF THE WOODS VOLUNTEER FIRE & RESCUE	0	20	0	8	1	5	34
Non-affiliated	0	11	0	0	0	0	11
Not currently affiliated	0	27	0	1	1	5	34
ORANGE COUNTY DEPARTMENT OF FIRE & EMS	6	22	0	3	12	18	61
ORANGE COUNTY RESCUE SQUAD INC	0	12	0	2	2	2	18
RAPPAHANNOCK	1	79	0	12	8	12	112
AMISSVILLE VOLUNTEER FIRE & RESCUE CO., INC.	0	29	0	2	5	4	40
CASTLETON COMMUNITY VOLUNTEER FIRE COMPANY	0	8	0	1	0	0	9
CHESTER GAP VOLUNTEER FIRE DEPARTMENT	0	4	0	1	1	0	6
FLINT HILL VOLUNTEER FIRE COMPANY, INC.	0	8	0	0	0	0	8
Non-affiliated	0	3	0	0	0	0	3
Not currently affiliated	1	6	0	1	0	0	8
SPERRYVILLE VOLUNTEER RESCUE SQUAD	0	9	0	2	1	5	17
WASHINGTON VOLUNTEER FIRE & RESCUE	0	12	0	5	1	3	21
Southwestern Virginia EMS Council	**253**	**970**	**0**	**215**	**224**	**358**	**2020**
CUMBERLAND PLATEAU	**140**	**246**	**0**	**38**	**48**	**72**	**544**
BUCHANAN	13	40	0	3	4	5	65
Affiliated with Inactive Agency	0	4	0	0	0	0	4
DAVENPORT LIFESAVING CREW INC	0	9	0	1	1	1	12
Non-affiliated	13	8	0	0	1	0	22
Not currently affiliated	0	3	0	0	1	1	5
OAKWOOD FIRE & RESCUE	0	5	0	1	0	0	6
PRATER VOLUNTEER RESCUE SQUAD, INC.	0	4	0	1	1	2	8
RESCUE 33 AMBULANCE SERVICE, INC.	0	5	0	0	0	1	6
SLATE CREEK VOLUNTEER FIRE DEPARTMENT	0	2	0	0	0	0	2
DICKENSON	50	40	0	4	9	7	110
CLINTWOOD VOLUNTEER RESCUE SQUAD, INC.	0	9	0	0	5	2	16

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
DICKENSON COUNTY AMBULANCE SERVICE	0	10	0	2	1	3	16
HAYSI RESCUE SQUAD	0	5	0	0	2	0	7
Non-affiliated	50	7	0	0	0	0	57
Not currently affiliated	0	1	0	0	1	0	2
SANDY RIDGE VOLUNTEER RESCUE SQUAD	0	8	0	2	0	2	12
RUSSELL	38	85	0	15	19	32	189
Affiliated with Inactive Agency	0	0	0	0	1	2	3
CASTLEWOOD FIRE AND RESCUE, INC.	0	11	0	4	2	5	22
CLEVELAND LIFESAVING CREW INC	0	7	0	5	4	0	16
DANTE RESCUE SQUAD INC	0	10	0	0	4	2	16
HIGHLANDS AMBULANCE SERVICE INC	0	13	0	0	1	1	15
LEBANON LIFE SAVING CREW	0	11	0	2	1	15	29
MERCY AMBULANCE SERVICE	0	9	0	3	4	6	22
NEW GARDEN RESCUE SQUAD	0	5	0	0	1	1	7
Non-affiliated	38	8	0	0	0	0	46
Not currently affiliated	0	11	0	1	1	0	13
TAZEWELL	39	81	0	16	16	28	180
ABBS VALLEY-BOISSEVAIN POCAHONTAS RESCUE SQUAD INC	0	2	0	3	0	3	8
Affiliated with Inactive Agency	0	13	0	4	3	8	28
BLUEFIELD VA RESCUE SQUAD	0	9	0	5	3	5	22
CHORES & ERRANDS AMBULANCE SERVICE INC	0	1	0	0	3	1	5
JEFFERSONVILLE VOLUNTEER RESCUE SQUAD	0	4	0	1	1	4	10
LEGACY AMBULANCE SERVICE	0	0	0	0	2	1	3
Non-affiliated	39	18	0	0	2	0	59
Not currently affiliated	0	9	0	0	0	0	9
TANNERSVILLE RESCUE SQUAD	0	9	0	1	1	3	14
THOMPSON VALLEY RESCUE SQUAD	0	5	0	0	0	0	5
TOWN OF RICHLANDS	0	11	0	2	1	3	17

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
LENOWISCO	**95**	**176**	**0**	**47**	**31**	**42**	**391**
LEE	5	31	0	6	5	2	49
Affiliated with Inactive Agency	0	1	0	0	1	0	2
JONESVILLE RESCUE SQUAD	0	4	0	2	0	0	6
KEOKEE VOLUNTEER FIRE & RESCUE	0	4	0	0	1	0	5
LEE COUNTY RESCUE SQUAD	0	2	0	2	0	0	4
Non-affiliated	5	6	0	0	0	0	11
Not currently affiliated	0	3	0	1	1	1	6
ST. CHARLES VOLUNTEER RESCUE SQUAD, INC.	0	2	0	0	0	0	2
THOMAS WALKER RESCUE SQUAD	0	9	0	1	2	1	13
NORTON	6	15	0	4	1	2	28
Affiliated with Inactive Agency	0	0	0	0	1	0	1
Non-affiliated	6	2	0	0	0	0	8
NORTON RESCUE SQUAD	0	12	0	4	0	2	18
Not currently affiliated	0	1	0	0	0	0	1
SCOTT	8	38	0	18	3	9	76
DUFFIELD VOLUNTEER FIRE & RESCUE	0	10	0	9	1	4	24
NICKELSVILLE RESCUE SQUAD	0	6	0	0	0	4	10
Non-affiliated	8	4	0	0	0	0	12
Not currently affiliated	0	6	0	1	0	0	7
SCOTT COUNTY LIFE SAVING CREW, INC.	0	12	0	8	2	1	23
WISE	76	92	0	19	22	29	238
Affiliated with Inactive Agency	0	4	0	2	1	1	8
APPALACHIA FIRE DEPT.	0	6	0	2	2	1	11
BIG STONE GAP RESCUE SQUAD INC	0	6	0	1	0	0	7
FRIENDSHIP AMBULANCE SERVICE	0	15	0	5	4	7	31
LIFECARE AMBULANCE SERVICE INC.	0	13	0	3	3	9	28
Non-affiliated	75	16	0	0	0	0	91
Not currently affiliated	1	8	0	1	0	1	11

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
POUND RESCUE SQUAD, INC.	0	5	0	0	3	2	10
SOUTHWEST AMBULANCE SERVICE, LLC	0	3	0	1	1	0	5
VALLEY VOLUNTEER FIRE DEPARTMENT	0	10	0	1	3	0	14
WISE RESCUE SQUAD, INC	0	6	0	3	5	8	22
MOUNT ROGERS	**18**	**548**	**0**	**130**	**145**	**244**	**1085**
BLAND	0	17	0	3	8	3	31
BLAND COUNTY VOLUNTEER RESCUE SQUAD	0	14	0	3	8	0	25
Non-affiliated	0	1	0	0	0	1	2
Not currently affiliated	0	2	0	0	0	2	4
BRISTOL	0	60	0	21	14	40	135
BRISTOL LIFE SAVING CREW	0	19	0	15	7	32	73
CITY OF BRISTOL FIRE DEPARTMENT	0	26	0	3	6	7	42
Non-affiliated	0	6	0	1	0	0	7
Not currently affiliated	0	9	0	2	1	1	13
CARROLL	2	66	0	12	21	38	139
Affiliated with Inactive Agency	0	7	0	1	1	1	10
CANA VOLUNTEER RESCUE SQUAD	0	6	0	2	1	10	19
CARROLL COUNTY FIRE & RESCUE	0	7	0	3	6	10	26
DUGSPUR RESCUE SQUAD	0	7	0	1	1	0	9
LAUREL FORK RESCUE SQUAD	0	7	0	0	1	2	10
LAUREL RESCUE SQUAD	1	5	0	2	0	4	12
Non-affiliated	1	5	0	0	0	0	6
Not currently affiliated	0	6	0	1	1	1	9
PIPERS GAP RESCUE SQUAD	0	16	0	2	10	10	38
GALAX	0	10	0	0	8	14	32
GALAX FIRE DEPARTMENT & RESCUE	0	6	0	0	1	0	7
GALAX-GRAYSON EMERGENCY MEDICAL SERVICES	0	2	0	0	6	14	22
Not currently affiliated	0	2	0	0	1	0	3
GRAYSON	1	69	0	8	9	14	101

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
BAYWOOD SEARCH & RESCUE	0	18	0	0	0	3	21
ELK CREEK RESCUE SQUAD	0	5	0	2	0	2	9
FRIES VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD	0	3	0	0	2	1	6
INDEPENDENCE VOLUNTEER RESCUE SQUAD	0	9	0	3	3	5	20
MOUNT ROGERS VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD	0	9	0	1	2	0	12
Non-affiliated	1	1	0	0	0	0	2
Not currently affiliated	0	6	0	0	0	0	6
RUGBY VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD	0	15	0	2	1	3	21
TROUTDALE VOLUNTEER RESCUE SQUAD	0	3	0	0	1	0	4
SMYTH	5	86	0	27	35	30	183
MARION LIFE SAVING & FIRST AID CREW	5	20	0	11	10	6	52
NEBO VOLUNTEER FIRE DEPARTMENT	0	7	0	0	1	1	9
Non-affiliated	0	8	0	1	0	0	9
Not currently affiliated	0	10	0	1	0	1	12
RICHARDSON AMBULANCE SERVICE	0	9	0	4	8	6	27
SALTVILLE RESCUE SQUAD	0	4	0	2	3	3	12
SMYTH COUNTY AMBULANCE SERVICE	0	12	0	1	2	4	19
SUGAR GROVE LIFE SAVING CREW, INC.	0	5	0	1	3	2	11
TOWN OF CHILHOWIE FIRE DEPARTMENT	0	8	0	4	4	7	23
TRINITY AMBULANCE SERVICE, LLC.	0	3	0	2	4	0	9
WASHINGTON	10	175	0	47	34	85	351
ABINGDON AMBULANCE SERVICE	0	20	0	5	12	25	62
Affiliated with Inactive Agency	0	11	0	3	2	5	21
BRUMLEY GAP VOL. FIRE DEPT.	0	6	0	1	0	2	9
DAMASCUS VOLUNTEER RESCUE SQUAD INC	0	11	0	6	3	1	21
GLADE SPRING VOLUNTEER LIFE SAVING CREW	0	29	0	5	4	1	39
GOODSON-KINDERHOOK VOLUNTEER FIRE	0	13	0	3	1	0	17

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
DEPARTMENT							
GREEN SPRING VOLUNTEER FIRE DEPT.	0	7	0	3	1	2	13
Non-affiliated	10	20	0	1	0	1	32
Not currently affiliated	0	17	0	4	1	4	26
TOWN OF DAMASCUS POLICE DEPARTMENT	0	2	0	0	0	2	4
VALLEY RESCUE SQUAD	0	7	0	2	1	5	15
VIRGINIA STATE POLICE - MEDFLIGHT II	0	1	0	0	0	23	24
WASHINGTON COUNTY FIRE/RESCUE	0	9	0	5	1	4	19
WASHINGTON COUNTY LIFE SAVING CREW INC	0	22	0	9	8	10	49
WYTHE	0	65	0	12	16	20	113
Affiliated with Inactive Agency	0	4	0	1	2	3	10
GUARDIAN EMERGENCY MEDICAL SERVICES	0	7	0	5	6	7	25
LEAD MINES RESCUE SQUAD	0	10	0	0	5	2	17
Non-affiliated	0	6	0	0	0	0	6
Not currently affiliated	0	12	0	1	0	1	14
RURAL RETREAT VOLUNTEER EMERGENCY SERVICES, INC.	0	8	0	4	3	0	15
WYTHE COUNTY RESCUE SQUAD	0	18	0	1	0	7	26
Thomas Jefferson EMS Council	**44**	**1018**	**23**	**113**	**252**	**308**	**1758**
THOMAS JEFFERSON	**44**	**1018**	**23**	**113**	**252**	**308**	**1758**
ALBEMARLE	18	293	4	18	46	80	459
Affiliated with Inactive Agency	1	19	0	1	1	1	23
ALBEMARLE COUNTY DEPARTMENT OF FIRE AND RESCUE	4	65	0	5	20	45	139
EARLYSVILLE VOLUNTEER FIRE COMPANY	0	15	0	0	1	2	18
Non-affiliated	3	65	1	0	1	0	70
NORTH GARDEN VOLUNTEER FIRE COMPANY	5	7	0	1	1	0	14
Not currently affiliated	1	36	0	1	0	8	46
SCOTTSVILLE VOLUNTEER FIRE DEPARTMENT	2	15	0	1	0	0	18

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
SCOTTSVILLE VOLUNTEER RESCUE SQUAD	0	25	1	2	4	4	36
SEMINOLE TRAIL VOLUNTEER FIRE DEPARTMENT	2	18	0	0	5	0	25
STONY POINT VOLUNTEER FIRE COMPANY	0	11	0	0	0	1	12
WESTERN ALBEMARLE RESCUE SQUAD	0	17	2	7	13	19	58
CHARLOTTESVILLE	1	264	13	33	89	110	510
CHARLOTTESVILLE FIRE DEPARTMENT	0	60	0	3	16	11	90
CHARLOTTESVILLE-ALBEMARLE RESCUE SQUAD	0	100	13	15	41	29	198
Non-affiliated	1	53	0	1	0	1	56
Not currently affiliated	0	33	0	2	2	4	41
PEGASUS FLIGHT OPERATIONS	0	9	0	0	6	20	35
UVA HEALTH SYSTEM - SPECIAL EVENTS MEDICAL MANAGEMENT	0	4	0	7	14	21	46
UVA HEALTH SYSTEMS PATIENT TRANSPORT	0	5	0	5	10	24	44
FLUVANNA	10	85	4	12	18	12	141
FLUVANNA COUNTY VOLUNTEER FIRE DEPARTMENT	0	6	0	1	1	0	8
FLUVANNA RESCUE SQUAD	0	7	2	1	2	1	13
LAKE MONTICELLO VOLUNTEER RESCUE SQUAD	0	41	2	10	15	11	79
Non-affiliated	9	16	0	0	0	0	25
Not currently affiliated	1	15	0	0	0	0	16
GREENE	0	67	0	7	10	6	90
GREENE COUNTY EMS	0	1	0	2	1	1	5
GREENE COUNTY RESCUE SQUAD	0	21	0	4	7	4	36
Non-affiliated	0	14	0	0	0	0	14
Not currently affiliated	0	15	0	0	0	0	15
RUCKERSVILLE VOLUNTEER FIRE COMPANY, INC.	0	6	0	1	1	1	9
STANARDSVILLE VOLUNTEER FIRE COMPANY	0	10	0	0	1	0	11
LOUISA	4	198	2	25	41	41	311
Affiliated with Inactive Agency	0	14	0	4	4	1	23
BUMPASS VOLUNTEER FIRE DEPARTMENT	0	3	0	0	0	1	4

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
HOLLY GROVE VOLUNTEER RESCUE SQUAD	1	15	0	4	3	5	28
LAKE ANNA RESCUE, INC	0	10	0	4	2	3	19
LOCUST CREEK VOLUNTEER FIRE DEPARTMENT	1	9	0	0	0	1	11
LOUISA COUNTY DEPARTMENT OF FIRE AND EMS	0	39	1	8	20	17	85
LOUISA COUNTY RESCUE SQUAD	0	24	1	4	6	7	42
MINERAL RESCUE SQUAD, INC	0	19	0	1	5	1	26
Non-affiliated	2	16	0	0	0	0	18
NORTH ANNA POWER STATION	0	28	0	0	1	0	29
Not currently affiliated	0	21	0	0	0	5	26
MADISON	0	28	0	6	13	24	71
MADISON COUNTY EMERGENCY MEDICAL SERVICES	0	0	0	0	7	22	29
MADISON COUNTY RESCUE SQUAD	0	19	0	6	6	1	32
Non-affiliated	0	2	0	0	0	1	3
Not currently affiliated	0	7	0	0	0	0	7
NELSON	11	83	0	12	35	35	176
Affiliated with Inactive Agency	0	2	0	0	0	0	2
GLADSTONE VOLUNTEER FIRE & RESCUE SERVICES	0	6	0	0	1	1	8
MONTEBELLO VOLUNTEER FIRE/RESCUE	0	6	0	1	0	0	7
NELSON COUNTY RESCUE SQUAD, INC.	2	7	0	1	1	2	13
Non-affiliated	1	11	0	0	0	0	12
Not currently affiliated	1	4	0	0	0	2	7
ROCKFISH VALLEY VOLUNTEER FIRE DEPARTMENT	2	8	0	3	3	0	16
ROSELAND RESCUE SQUAD, INC.	2	25	0	2	1	0	30
WINTERGREEN FIRE DEPARTMENT	0	3	0	1	9	9	22
WINTERGREEN PROPERTY OWNERS VOLUNTEER RESCUE SQUAD	3	11	0	4	20	21	59
Tidewater EMS Council	**11**	**3125**	**20**	**1226**	**388**	**1242**	**6012**
EASTERN SHORE	**0**	**210**	**0**	**96**	**31**	**87**	**424**
ACCOMACK	0	171	0	74	27	61	333

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
ACCOMACK CO DEPT OF PUBLIC SAFETY	0	2	0	18	9	23	52
Affiliated with Inactive Agency	0	18	0	3	2	3	26
ATLANTIC VOLUNTEER FIRE AND RESCUE DEPARTMENT	0	13	0	2	0	1	16
BLOXOM VOLUNTEER FIRE COMPANY	0	20	0	12	2	4	38
CHINCOTEAGUE VOLUNTEER FIRE COMPANY	0	11	0	7	6	7	31
GREENBACKVILLE VOLUNTEER FIRE DEPARTMENT	0	11	0	3	0	3	17
MELFA VOLUNTEER FIRE & RESCUE	0	10	0	5	1	4	20
Non-affiliated	0	11	0	0	1	0	12
Not currently affiliated	0	10	0	0	0	0	10
OAK HALL RESCUE, INC.	0	15	0	3	1	1	20
ONANCOCK VOLUNTEER FIRE DEPARTMENT	0	2	0	7	2	2	13
ONLEY VOLUNTEER FIRE & RESCUE	0	9	0	3	0	1	13
PARKSLEY VOLUNTEER FIRE COMPANY, INC.	0	21	0	7	1	9	38
SAXIS VOLUNTEER FIRE AND RESCUE, INC.	0	10	0	0	1	1	12
TANGIER VOLUNTEER FIRE DEPARTMENT	0	0	0	0	0	1	1
VIRGINIA LIFELINE AMBULANCE SERVICE, INC.	0	3	0	0	0	0	3
WACHAPREAGUE VOLUNTEER FIRE COMPANY	0	5	0	4	1	1	11
NORTHAMPTON	0	39	0	22	4	26	91
CAPE CHARLES RESCUE SERVICE INC	0	11	0	1	0	4	16
COMMUNITY FIRE COMPANY INC	0	8	0	5	1	5	19
Non-affiliated	0	8	0	0	0	0	8
NORTHAMPTON COUNTY DEPARTMENT OF EMS	0	4	0	12	2	14	32
NORTHAMPTON FIRE & RESCUE, INC.	0	7	0	3	0	3	13
Not currently affiliated	0	1	0	1	1	0	3
TIDEWATER	**11**	**2915**	**20**	**1130**	**357**	**1155**	**5588**
CHESAPEAKE	0	428	0	122	33	114	697
CHESAPEAKE FIRE DEPARTMENT	0	219	0	113	31	94	457
Non-affiliated	0	150	0	0	0	6	156
Not currently affiliated	0	58	0	9	2	14	83

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
SOUTHERN MEDICAL TRANSPORTATION	0	1	0	0	0	0	1
FRANKLIN CITY	0	23	0	8	15	9	55
FRANKLIN FIRE & RESCUE	0	15	0	8	14	9	46
Non-affiliated	0	3	0	0	0	0	3
Not currently affiliated	0	5	0	0	1	0	6
ISLE OF WIGHT	1	160	1	27	40	85	314
Affiliated with Inactive Agency	0	2	0	0	0	2	4
CARROLLTON VOLUNTEER FIRE DEPARTMENT	0	24	0	3	11	10	48
ISLE OF WIGHT COUNTY EMERGENCY SERVICES	0	13	0	17	16	54	100
ISLE OF WIGHT VOLUNTEER RESCUE SQUAD, INC.	0	43	1	4	10	12	70
Non-affiliated	1	40	0	0	0	0	41
Not currently affiliated	0	17	0	0	0	2	19
WINDSOR VOLUNTEER RESCUE SQUAD	0	21	0	3	3	5	32
NORFOLK	0	186	14	280	55	198	733
CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS	0	0	0	0	0	16	16
NIGHTINGALE AIR AMBULANCE	0	4	0	0	1	13	18
Non-affiliated	0	87	0	0	0	10	97
NORFOLK AIRPORT AUTHORITY FIRE DEPARTMENT	0	20	0	2	0	2	24
NORFOLK DIVISION FEDERAL BUREAU OF INVESTIGATION	0	2	0	0	0	0	2
NORFOLK FIRE-RESCUE	0	15	14	275	52	148	504
Not currently affiliated	0	58	0	3	2	9	72
PORTSMOUTH	1	329	0	211	17	128	686
Affiliated with Inactive Agency	0	4	0	1	1	5	11
EMERGENCY MEDICAL RESPONSE, LLC.	0	13	0	1	3	10	27
Non-affiliated	0	46	0	0	0	4	50
Not currently affiliated	1	21	0	6	0	5	33
PORTSMOUTH FIRE, RESCUE & EMERGENCY SERVICES	0	0	0	183	3	68	254
TIDEWATER MEDICAL TRANSPORT, LLC.	0	3	0	4	3	1	11

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
TIDEWATER NAVY EMS - NAVY REGIONAL MEDICAL CENTER	0	242	0	16	7	35	300
SOUTHAMPTON	1	42	0	21	13	11	88
Affiliated with Inactive Agency	0	0	0	0	0	1	1
BOYKINS VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD INC	0	5	0	6	5	2	18
CAPRON VOLUNTEER FIRE & FIRST AID SQUAD	0	3	0	6	2	0	11
COURTLAND VOLUNTEER RESCUE SQUAD	1	7	0	3	1	4	16
IVOR VOLUNTEER RESCUE SQUAD	0	8	0	3	5	3	19
Non-affiliated	0	5	0	1	0	0	6
Not currently affiliated	0	5	0	0	0	1	6
SEDLEY VOLUNTEER FIRE DEPARTMENT	0	9	0	2	0	0	11
SUFFOLK	5	175	0	166	27	101	474
Affiliated with Inactive Agency	3	4	0	1	0	1	9
BASF CORPORATION	1	6	0	0	0	0	7
CHUCKATUCK VOLUNTEER FIRE DEPARTMENT	0	4	0	5	1	0	10
DRIVER VOLUNTEER FIRE DEPARTMENT INC	0	4	0	4	2	4	14
NANSEMOND-SUFFOLK VOLUNTEER RESCUE SQUAD	0	33	0	1	11	24	69
Non-affiliated	1	73	0	0	1	2	77
Not currently affiliated	0	27	0	4	1	6	38
SUFFOLK FIRE & RESCUE	0	24	0	151	11	64	250
VIRGINIA BEACH	3	1572	5	295	157	509	2541
Affiliated with Inactive Agency	0	6	0	0	0	14	20
BLACKWATER VOLUNTEER RESCUE	0	3	0	2	1	3	9
CHESAPEAKE BEACH FIRE & RESCUE	0	18	0	3	0	1	22
CITY OF VIRGINIA BEACH DEPARTMENT OF EMS	0	689	2	204	73	242	1210
CREEDS VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD	0	5	0	1	2	0	8
DAVIS CORNER VOLUNTEER FIRE & RESCUE	0	23	0	3	0	4	30

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Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
KEMPSVILLE VOLUNTEER RESCUE SQUAD	0	25	0	6	3	16	50
MEDICAL TRANSPORT, LLC	0	175	1	21	42	111	350
MID-ATLANTIC REGIONAL AMBULANCE, INC.	0	8	0	0	1	0	9
Non-affiliated	1	239	0	3	1	23	267
Not currently affiliated	2	145	0	12	9	31	199
OCEAN PARK VOLUNTEER FIRE & RESCUE	0	18	1	3	3	7	32
PLAZA VOLUNTEER RESCUE SQUAD	0	50	1	9	4	11	75
PRINCESS ANNE COURTHOUSE RESCUE SQUAD	0	41	0	4	9	11	65
SANDBRIDGE RESCUE AND FIRE, INC.	0	16	0	2	1	3	22
SPECIAL EVENT PROVIDERS OF EMERGENCY MEDICINE	0	4	0	2	2	2	10
VIRGINIA BEACH LIFESAVING	0	26	0	5	4	8	43
VIRGINIA BEACH VOLUNTEER RESCUE SQUAD	0	81	0	15	2	22	120
Western Virginia EMS Council	**77**	**2495**	**3**	**260**	**575**	**769**	**4179**
NEW RIVER VALLEY	**1**	**557**	**0**	**72**	**119**	**122**	**871**
FLOYD	0	56	0	4	18	14	92
FLOYD COUNTY EMS INC	0	5	0	0	11	9	25
FLOYD COUNTY LIFE SAVING AND FIRST AID SQUAD INC	0	24	0	2	6	4	36
Non-affiliated	0	7	0	1	0	0	8
Not currently affiliated	0	20	0	1	1	1	23
GILES	0	74	0	3	6	16	99
Affiliated with Inactive Agency	0	1	0	0	0	0	1
CELANESE CORPORATION	0	11	0	2	0	5	18
GILES LIFESAVING AND RESCUE SQUAD INC	0	24	0	1	3	5	33
NEWPORT VOLUNTEER RESCUE SQUAD	0	15	0	0	2	6	23
Non-affiliated	0	11	0	0	0	0	11
Not currently affiliated	0	12	0	0	1	0	13
MONTGOMERY	1	325	0	58	59	49	492
Affiliated with Inactive Agency	0	10	0	0	0	0	10
BLACKSBURG RESCUE SQUAD	0	67	0	22	20	14	123

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
CHRISTIANSBURG RESCUE SQUAD	0	48	0	12	13	14	87
LIFELINE AMBULANCE SERVICE	0	3	0	0	4	9	16
LONG SHOP-MCCOY VOLUNTEER FIRE DEPARTMENT/RESCUE SQUAD	0	10	0	6	0	1	17
Non-affiliated	0	47	0	0	0	1	48
Not currently affiliated	1	61	0	6	5	5	78
RINER VOLUNTEER RESCUE SQUAD INC.	0	34	0	3	6	1	44
SHAWSVILLE VOLUNTEER RESCUE SQUAD	0	14	0	3	1	0	18
VIRGINIA TECH RESCUE SQUAD	0	31	0	6	10	4	51
PULASKI	0	74	0	6	28	21	129
Non-affiliated	0	15	0	0	0	0	15
Not currently affiliated	0	14	0	0	2	1	17
RADFORD ARMY AMMUNITION FIRE/RESCUE	0	25	0	2	1	1	29
REGIONAL EMS, INC.	0	16	0	3	24	19	62
TWIN COMMUNITY VOLUNTEER FIRE DEPARTMENT	0	4	0	1	1	0	6
RADFORD	0	28	0	1	8	22	59
Affiliated with Inactive Agency	0	0	0	0	0	2	2
Non-affiliated	0	9	0	0	0	0	9
Not currently affiliated	0	2	0	0	1	1	4
RADFORD EMERGENCY MEDICAL SERVICES	0	5	0	1	6	19	31
RADFORD UNIVERSITY EMS	0	12	0	0	1	0	13
PIEDMONT	**45**	**982**	**0**	**116**	**170**	**218**	**1531**
DANVILLE	10	303	0	27	35	33	408
DANVILLE FIRE DEPARTMENT	1	112	0	2	3	1	119
DANVILLE LIFE SAVING & FIRST AID CREW INC	0	70	0	11	18	18	117
GOODYEAR TIRE AND RUBBER COMPANY	7	44	0	0	1	0	52
Non-affiliated	2	3	0	0	0	0	5
Not currently affiliated	0	5	0	0	0	1	6
REGIONAL ONE EMS	0	46	0	11	8	12	77

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
TUNSTALL VOLUNTEER FIRE DEPARTMENT	0	23	0	3	5	1	32
FRANKLIN COUNTY	2	235	0	9	26	56	328
Affiliated with Inactive Agency	0	39	0	3	9	6	57
FRANKLIN COUNTY PUBLIC SAFETY	1	101	0	3	12	45	162
FRANKLIN COUNTY RESCUE SQUAD	0	15	0	0	1	2	18
Non-affiliated	1	45	0	0	1	2	49
Not currently affiliated	0	23	0	0	0	0	23
SCRUGGS FIRE DEPARTMENT AND RESCUE SQUAD, INC.	0	12	0	3	3	1	19
HENRY	8	117	0	12	27	55	219
BASSETT RESCUE SQUAD INC	2	18	0	4	8	9	41
FIELDALE-COLLINSVILLE RESCUE SQUAD	1	14	0	3	6	7	31
HENRY COUNTY DEPARTMENT OF PUBLIC SAFETY	3	52	0	5	11	34	105
Non-affiliated	0	6	0	0	0	0	6
Not currently affiliated	2	18	0	0	0	0	20
RIDGEWAY DISTRICT RESCUE SQUAD, INC.	0	9	0	0	2	5	16
MARTINSVILLE	6	43	0	6	32	27	114
Affiliated with Inactive Agency	1	0	0	0	0	0	1
MARTINSVILLE FIRE & EMS	5	18	0	3	22	18	66
Non-affiliated	0	1	0	0	0	0	1
Not currently affiliated	0	2	0	0	0	0	2
PROVIDENCE EMS TRANSPORT LLC	0	8	0	0	2	1	11
STONE AMBULANCE SERVICE, INC.	0	14	0	3	8	8	33
PATRICK	8	62	0	33	17	18	138
Affiliated with Inactive Agency	0	0	0	0	1	1	2
ARARAT RESCUE SQUAD	0	3	0	4	0	0	7
BLUE RIDGE VOLUNTEER RESCUE SQUAD	0	5	0	0	1	4	10
CCDF VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD INC	0	5	0	5	2	1	13
FAIRYSTONE VOLUNTEER FIRE DEPARTMENT, INC	1	4	0	5	0	1	11

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
JEB STUART RESCUE SQUAD	0	11	0	3	4	2	20
MOOREFIELD STORE FIRE DEPARTMENT	1	7	0	0	0	0	8
Non-affiliated	1	2	0	0	0	0	3
Not currently affiliated	0	5	0	2	0	0	7
PATRICK COUNTY EMERGENCY SERVICES	0	0	0	1	1	1	3
SMITH RIVER RESCUE SQUAD	1	13	0	9	3	6	32
STUART VOLUNTEER FIRE DEPARTMENT	4	2	0	3	1	0	10
VESTA RESCUE SQUAD	0	5	0	1	4	2	12
PITTSYLVANIA	11	222	0	29	33	29	324
640 COMMUNITY RESCUE	0	7	0	2	2	0	11
BACHELORS HALL VOLUNTEER FIRE DEPARTMENT	0	3	0	1	2	0	6
BLAIRS VOLUNTEER FIRE & RESCUE INC	1	21	0	1	1	2	26
BROSVILLE COMMUNITY VOLUNTEER FIRE DEPARTMENT	0	11	0	2	2	6	21
CALLANDS VOLUNTEER FIRE AND RESCUE INC	0	10	0	3	3	1	17
CASCADE VOLUNTEER FIRE DEPARTMENT	0	5	0	0	1	1	7
CHATHAM RESCUE SQUAD	0	11	0	4	5	3	23
CLIMAX VOLUNTEER FIRE COMPANY INC	0	3	0	0	0	0	3
COOL BRANCH RESCUE SQUAD	0	13	0	2	1	1	17
DRY FORK VOLUNTEER FIRE DEPARTMENT INC	1	5	0	0	0	0	6
GRETNA RESCUE SQUAD	0	12	0	3	4	2	21
KEELING VOLUNTEER FIRE DEPARTMENT	4	2	0	0	0	0	6
KENTUCK VOLUNTEER FIRE DEPARTMENT, INC.	0	11	0	1	2	1	15
LAUREL GROVE VOLUNTEER FIRE & RESCUE INC	0	15	0	2	2	1	20
MOUNT CROSS VOLUNTEER FIRE & RESCUE, INC	0	6	0	0	0	1	7
MOUNT HERMON VOLUNTEER FIRE DEPARTMENT	0	17	0	3	3	5	28
Non-affiliated	2	19	0	0	0	0	21
Not currently affiliated	0	23	0	2	3	1	29
RINGGOLD VOLUNTEER FIRE DEPARTMENT	0	25	0	3	1	4	33
RIVERBEND VOLUNTEER FIRE DEPARTMENT	3	3	0	0	1	0	7

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
WESTERN VIRGINIA	**31**	**956**	**3**	**72**	**286**	**429**	**1777**
ALLEGHANY	7	80	3	26	18	12	146
BOILING SPRINGS VOLUNTEER FIRE DEPARTMENT AND RESCUE SQUAD INC	0	7	0	3	2	0	12
CLIFTON FORGE RESCUE SQUAD	1	24	0	7	3	2	37
DUNLAP FIRE AND RESCUE	0	9	3	4	4	2	22
FALLING SPRING RESCUE SQUAD INC	0	6	0	3	5	4	18
IRON GATE VOLUNTEER FIRE DEPARTMENT	0	1	0	6	3	2	12
Non-affiliated	6	11	0	0	0	0	17
Not currently affiliated	0	7	0	0	0	0	7
SHARON VOLUNTEER FIRE DEPARTMENT, INC.	0	15	0	3	1	2	21
BOTETOURT	10	104	0	6	24	30	174
Affiliated with Inactive Agency	1	12	0	2	1	4	20
BLUE RIDGE VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD	0	9	0	0	2	0	11
BOTETOURT COUNTY EMERGENCY SERVICES	1	41	0	3	17	24	86
EAGLE ROCK VOLUNTEER FIRE DEPARTMENT/RESCUE SQUAD	2	7	0	0	2	1	12
FINCASTLE RESCUE SQUAD	0	7	0	0	1	0	8
Non-affiliated	6	8	0	0	0	0	14
Not currently affiliated	0	20	0	1	1	1	23
COVINGTON	0	34	0	15	7	1	57
Affiliated with Inactive Agency	0	1	0	0	0	0	1
COVINGTON RESCUE SQUAD	0	14	0	9	5	1	29
Non-affiliated	0	2	0	0	0	0	2
Not currently affiliated	0	3	0	0	0	0	3
WESTVACO RESCUE SQUAD	0	14	0	6	2	0	22
CRAIG	13	28	0	3	12	10	66
CRAIG COUNTY EMERGENCY SERVICES	4	3	0	1	5	8	21

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
CRAIG COUNTY RESCUE SQUAD - EMS INC	6	15	0	2	6	2	31
Non-affiliated	1	1	0	0	0	0	2
Not currently affiliated	2	3	0	0	1	0	6
PAINT BANK FIRE & RESCUE	0	6	0	0	0	0	6
ROANOKE CITY	0	295	0	9	119	225	648
Affiliated with Inactive Agency	0	10	0	0	4	4	18
CARILION CLINIC PATIENT TRANSPORTATION	0	65	0	5	37	106	213
FIRST CALL AMBULANCE SERVICE OF VIRGINIA, LLC	0	6	0	1	4	6	17
JEFFERSON COLLEGE OF HEALTH SCIENCE	0	4	0	0	1	11	16
MED-TRANS CORPORATION DBA CARILION CLINIC LIFE-GUARD	0	11	0	1	1	23	36
Non-affiliated	0	26	0	0	1	1	28
Not currently affiliated	0	24	0	1	3	4	32
ROANOKE EMERGENCY MEDICAL SERVICES INC	0	20	0	0	6	7	33
ROANOKE FIRE - EMS DEPARTMENT	0	129	0	1	62	63	255
ROANOKE COUNTY	1	293	0	11	84	105	494
Affiliated with Inactive Agency	0	5	0	0	0	3	8
BENT MOUNTAIN FIRST AID & RESCUE SQUAD INC	0	14	0	1	1	1	17
CATAWBA-MASON'S COVE RESCUE SQUAD INC	0	12	0	0	0	4	16
CAVE SPRING FIRST AID & RESCUE SQUAD	0	45	0	4	6	14	69
FORT LEWIS VOLUNTEER FIRE DEPARTMENT INC	0	4	0	0	1	1	6
Non-affiliated	0	40	0	1	2	4	47
Not currently affiliated	0	47	0	0	3	8	58
READ MOUNTAIN FIRE/RESCUE	1	16	0	3	3	6	29
ROANOKE COUNTY FIRE & RESCUE	0	66	0	1	58	51	176
ROANOKE COUNTY FIRE DEPARTMENT/RESCUE SQUAD - #5 HOLLINS	0	25	0	0	1	5	31
VINTON FIRE AND EMS	0	2	0	0	5	2	9
VINTON FIRST AID CREW, INC	0	17	0	1	4	6	28

Provider Level By Council, Planning District, Agency
01-05-2015

Row Labels	EMR/FR	EMT	AEMT	Enhanced	I-99	Paramedic	Total
SALEM	0	122	0	2	22	46	192
Affiliated with Inactive Agency	0	2	0	0	1	0	3
AMERICAN NATIONAL UNIVERSITY EMS	0	0	0	1	1	10	12
Non-affiliated	0	13	0	0	0	0	13
Not currently affiliated	0	20	0	0	1	1	22
SALEM FIRE - EMS DEPARTMENT	0	41	0	0	18	27	86
SALEM RESCUE SQUAD	0	26	0	1	1	8	36
YOKOHAMA INDUSTRIAL RESCUE SQUAD	0	20	0	0	0	0	20
Grand Total	**1000**	**24342**	**69**	**2896**	**4013**	**7376**	**39697**

Appendix

E

Standards of Excellence

Aim of the Program

‘To identify and recognize EMS agencies that strive to operate above the standards and requirements of the Virginia EMS Regulations’

Virginia
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Virginia Department of Health

Overview

In the beginning…

Overview

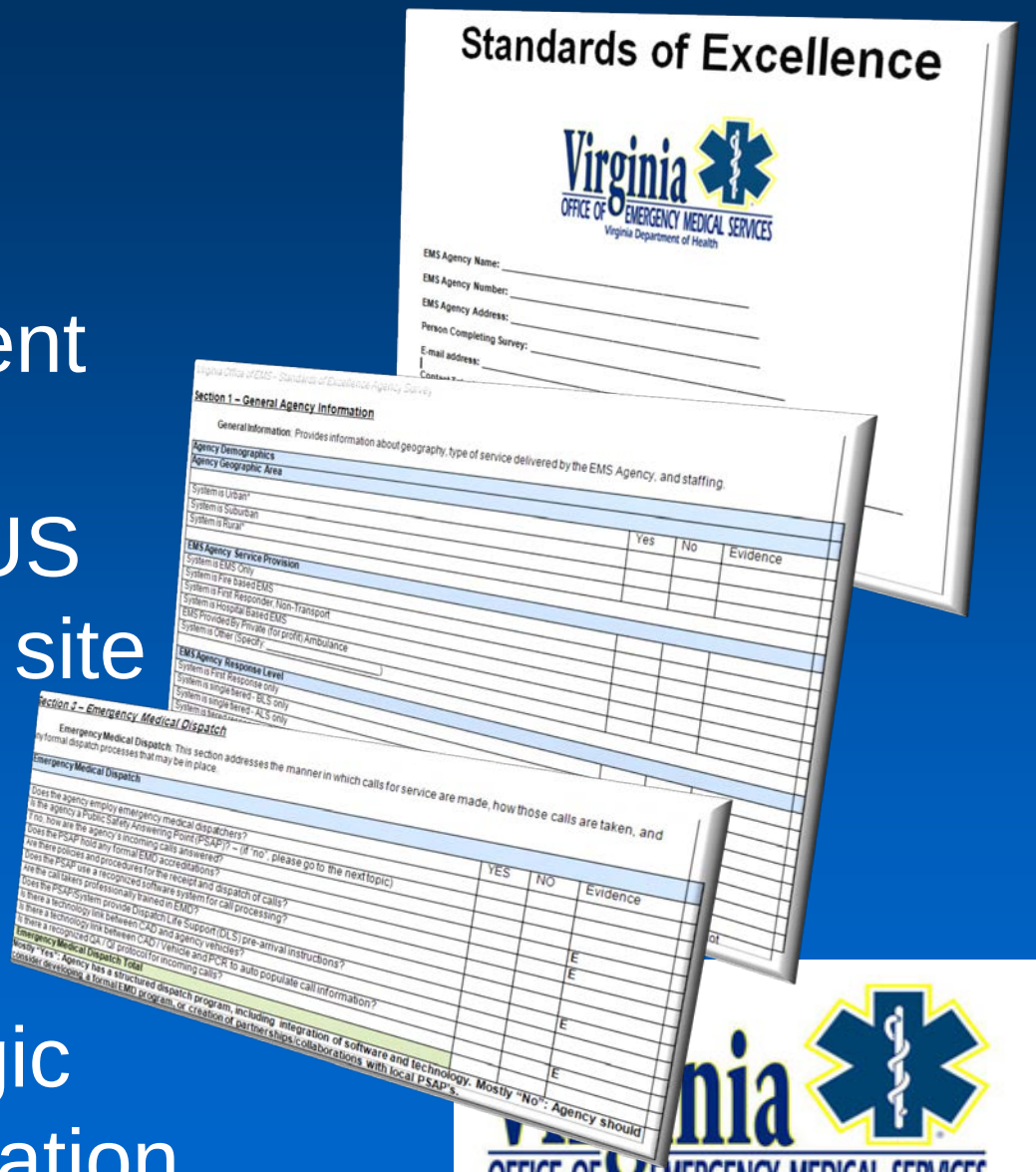
What it evolved to…

The SOE Document

8 Section Self Assessment Document

Self assessment PLUS means to generate a site visit & evidence presentation

Generation of strategic report on the organization



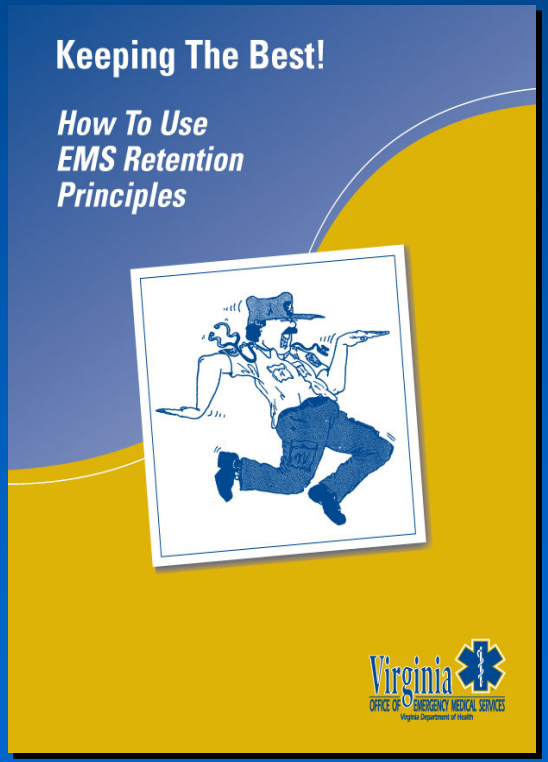
Overview

Less about the “Stuff”, and more about the “CHARACTER” of the organization

Standards of Excellence

How can this impact your retention of members?

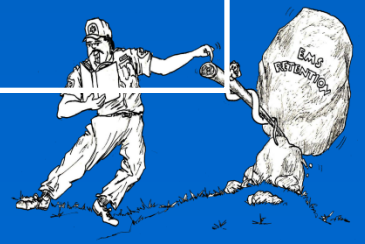
Keeping the Best! How to Use EMS Retention Principles



How can you use SoE and KTB together to improve your agency?

- The Life-Cycle Principle
- The Belonging Principle
- The Success Principle
- The Friends & Family Principle
- The Leader's Role in Retention

- Leadership and Management
- Emergency Medical Dispatch
- Clinical measures
- Life Safety
- Operational Medical Direction
- Community Support and Involvement
- Recruitment and Retention
- Performance and Risk



(KTB) The Leader's Role in Retention

What I do	Impact it Has on Others

EMS Leadership and Management

This section addresses agency operational and financial policies and procedures, performance evaluation for personnel, training programs, preceptorship programs, and maintenance of records

Section 2 – EMS Leadership and Management

EMS Leadership and Management: This section addresses agency operational and financial policies and procedures, performance evaluation for personnel, training programs, preceptorship programs, and maintenance of records.

Agency Policy and Procedures			
	YES	NO	Evidence
Does the agency have a documented set of Standard Operating Procedures/Guidelines (SOP)?			E
Is a copy of the SOP document easily accessible by every member?			
Has the agency SOP document been reviewed and revised in the last five years?			E
Does the agency have Human Resources (HR) policies?			E
Were the HR policies reviewed and revised in the last five years?			E
Does the agency have a dedicated position that maintains & secures HR records?			E
Does the agency have training program/materials that relates to handling HR functions?			
Is there a Performance Improvement Program for personnel who do not meet policy standards?			
Does the agency have a formal, written disciplinary review process that is followed prior to dismissing personnel from the organization?			
Mostly "Yes": Agency has structured, and easily defensible policies and procedures. Mostly "No" adopting/revising policies and procedures for operations and/or HR.			

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EMS Leadership and Management

Key Points

Is your leadership team mission ready?

Do you have a plan (strategic) and do more people than just you know what it is?

This section addresses agency operational and financial policies and procedures, performance evaluation for personnel, training programs, preceptorship programs, and maintenance of records

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Recruitment and Retention

Addresses any structured recruitment programs that the agency has in place, agency expectations for new members, agency orientation programs, retention programs, incentives that the agency offers to it's members.

Section 8 – Recruitment and Retention

Recruitment and Retention: Addresses any structured recruitment programs that the agency has in place, agency expectations for new members, agency orientation programs, retention programs, incentives that the agency offers to it's members.

Selection Process			
	YES	NO	Evidence
Does the agency have a recruitment officer who handles/tracks all new members?			E
Does the agency conduct recruitment campaigns to attract new members?			
How does the agency determine the number of members needed to meet call demand?			
Does the agency identify potential recruits in the community?			
How often does the agency do recruitment campaigns?			
Does the agency membership reflect the diversity of the community?			
Is the agency recruitment process tailored to parties of various backgrounds, skill sets and experience?			
Mostly "Yes": Agency has structured recruitment program with consideration of community demographics. Mostly "No": Agency should establish a structured recruitment program in order to increase agency membership, and conside training program.			
Agency Expectations			
Does the agency have written job descriptions for each position within the organization?			
Does the agency document and communicate agency expectations of personnel to new members?			
Does the agency document and communicate what the agency provides (materials, uniforms, equipment new personnel?			
Mostly "Yes": Agency clearly communicates expectations to new personnel, and vice versa. Most communicate expectations to new members, and provide opportunity for new members to commu			

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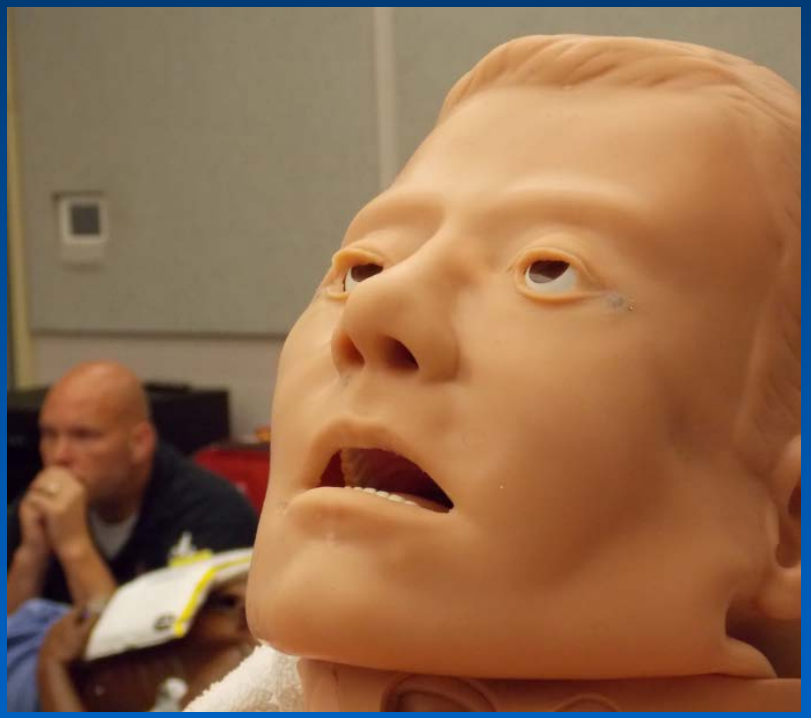
Recruitment and Retention



Key Points

Is everyone recruiting and great advocates for your organization?

The new member challenge - Induction and orientation versus badge and a pulse?

How do you keep the best?

Addresses any structured recruitment programs that the agency has in place, agency expectations for new members, agency orientation programs, retention programs, incentives that the agency offers to it's members

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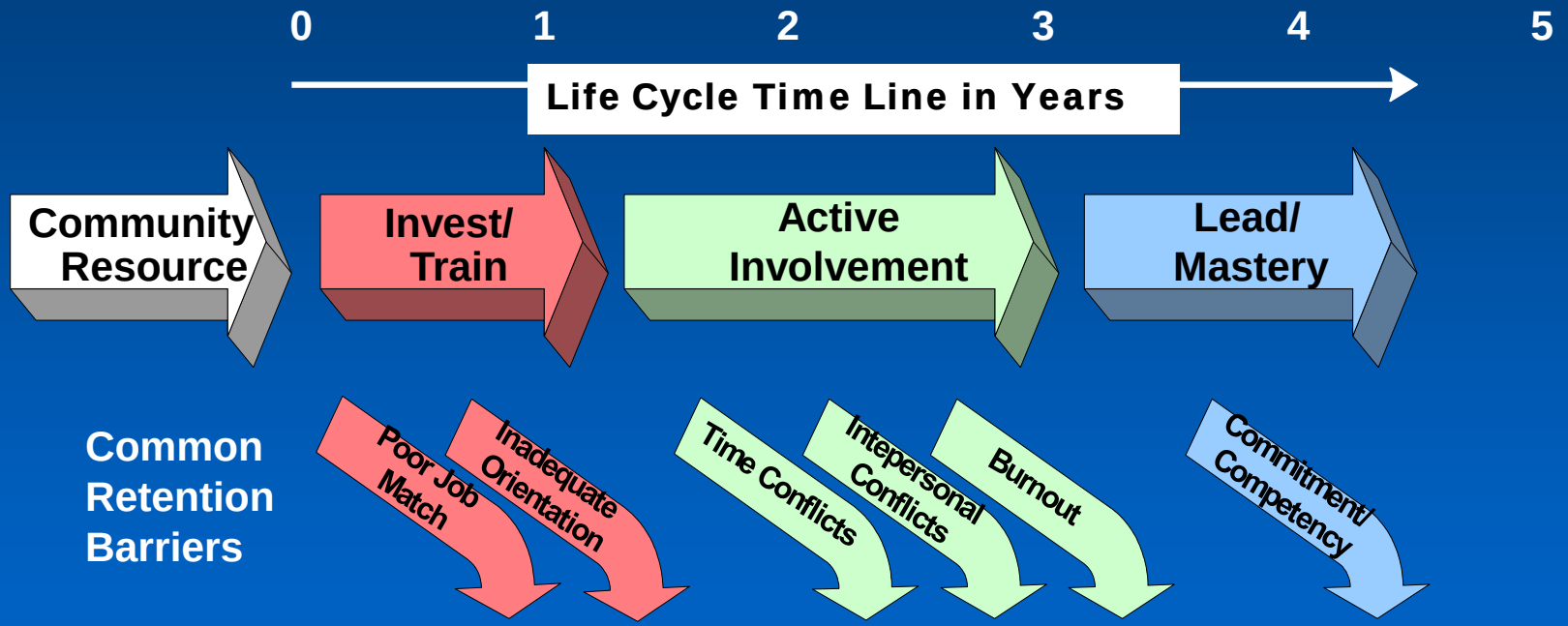
(KTB) Retention Principles

The Life Cycle Model



Thank You & Questions

Rob Lawrence rlawrence@raaems.org

David Tesh teshd@chesterfield.gov

Appendix

F

Virginia Department of Health
Trauma Care Performance Improvement Report
Baseline – Calendar Year 2013 Data

Virginia Department of Health
Office of Emergency Medical Services
Division of Trauma/Critical Care
1041 Technology Park Drive
Glen Allen, Virginia 23059
(804) 888-9100

This report is based on the deliberations of the Trauma Performance Improvement Committee and analyses performed by OEMS staff.

Report Date – December 2014

Virginia Trauma Care Performance Improvement Report
Baseline – Calendar Year 2013 Data

Core Objective 3 for the Trauma System Oversight & Management Committee (TSO&MC) states that the Committee will advise the Virginia Department of Health, Office of Emergency Medical Services on matters relating to maintaining a performance improvement process that supports the trauma center designation process, trauma triage plan, and improves trauma care throughout Virginia *(§ 32.1-111.3:B.3)*. The Trauma Performance Improvement Committee (TPIC) of the TSO&MC has been tasked with developing a performance improvement program for monitoring the quality of care, consistent with other components of the Emergency Medical Services Plan.

This inaugural annual analysis will focus on the frequency of (1) incorrect triage in comparison to the total number of trauma patients delivered to hospitals by emergency medical services (EMS) agencies and (2) incorrect interfacility transfer of trauma patients. The results reported here represent a high level summary of the findings. Specific instances of incorrect trauma triage or incorrect interfacility transfer will be provided to the appropriate EMS director or hospital, respectively. The provider will be given an opportunity to provide feedback which may explain special circumstances in which an exception occurred. The findings of this report and any feedback from providers will be used to drive education and improve the Trauma Triage Plan.

Incorrect Trauma Triage by Emergency Medical Services Agencies

For the purpose of this report, *incorrect trauma triage* is defined as pre hospital cases that are deemed to be traumas (see Table 1) and where one or more of the Virginia Step 1 Field Trauma Triage Criteria (see Figure 1) were met, *but* the patient was not transported to a Level I or Level II trauma center or was not taken by ground ambulance to a landing zone or other such location for air EMS transport (presumably to a Level I or Level II trauma center). Since several EMS regions do not have a Level I or Level II trauma center within their boundaries, trauma patients that met one or more of the aforementioned criteria and who were transported to Level III trauma centers (under certain conditions described below) were also counted as being correctly triaged.

During calendar year 2013, only 5.2 percent (66,906/1,219,358) of the records in the Virginia Pre Hospital Information Bridge (VPHIB) were classified as trauma cases. Of these, 96.5 percent (64,543/66,906) were "True 911" situations (i.e., the type of service requested was a 911 scene response and the patient was treated and transported by EMS). Unfortunately, 42.2 percent (27,210/64,543) of the "True 911" trauma cases were missing systolic blood pressure (SBP), respiratory rate (RR), *and* Glasgow Coma Scale (GCS) values. This missing data means that it is not possible to report on the appropriateness of the triaging of these trauma patients. Figure 2 displays the impact of this missing information by EMS regions. The EMS region with the most complete reporting of the necessary vital signs data was Peninsulas (89.0 percent) and Tidewater, its nearby neighboring EMS region, had the least complete reporting of this important

information (43.6 percent). The lack of complete documentation will be incorporated into the individual EMS agency reports.

Table 1. Definition of Trauma Patients for VPHIB Data

*NOTE: Both the **Complaint Reported by Dispatch** and the **Provider's Primary Impression** must be listed below in order to classify the record as a trauma case.*

Complaint Reported by Dispatch	
Assault	Hemorrhage/Laceration
Assault – Sexual	Industrial Accident/Inaccessible Incident/
Auto vs. Pedestrian	Other Entrapments (Non-Vehicle)
Burns	Ingestion/Poisoning
CO Poisoning/Hazmat	Machine/Equipment Injury
Drowning	MCI (Multiple Casualty Incident)
Electrocution	Stab/Gunshot Wound
Eye Problem / Injury	Traffic/Transportation Accident
Fall Victim	Traumatic Injury
Provider's Primary Impression	
Bleeding	Smoke Inhalation
Electrocution	Toxic Exposure
Inhalation Injury (Toxic Gas)	Traumatic Injury
Poisoning/Drug Ingestion	

Figure 1. Virginia Field Trauma Triage Decision Scheme

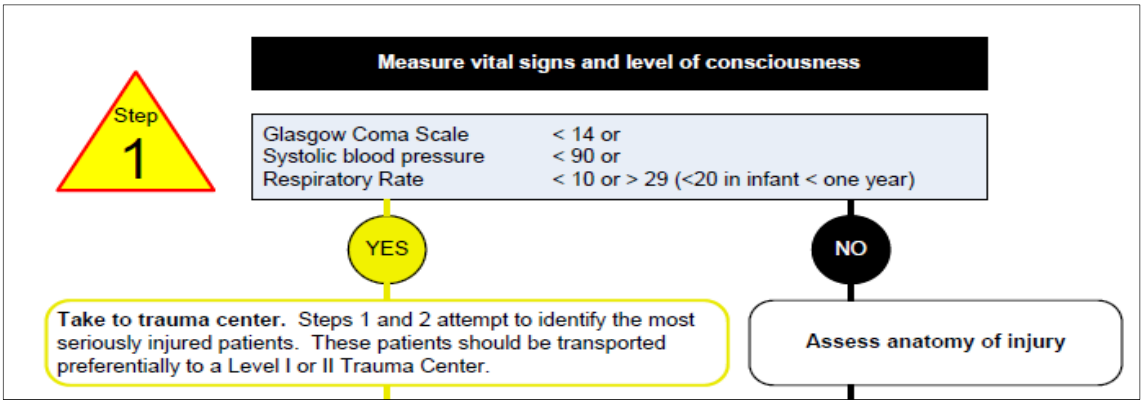
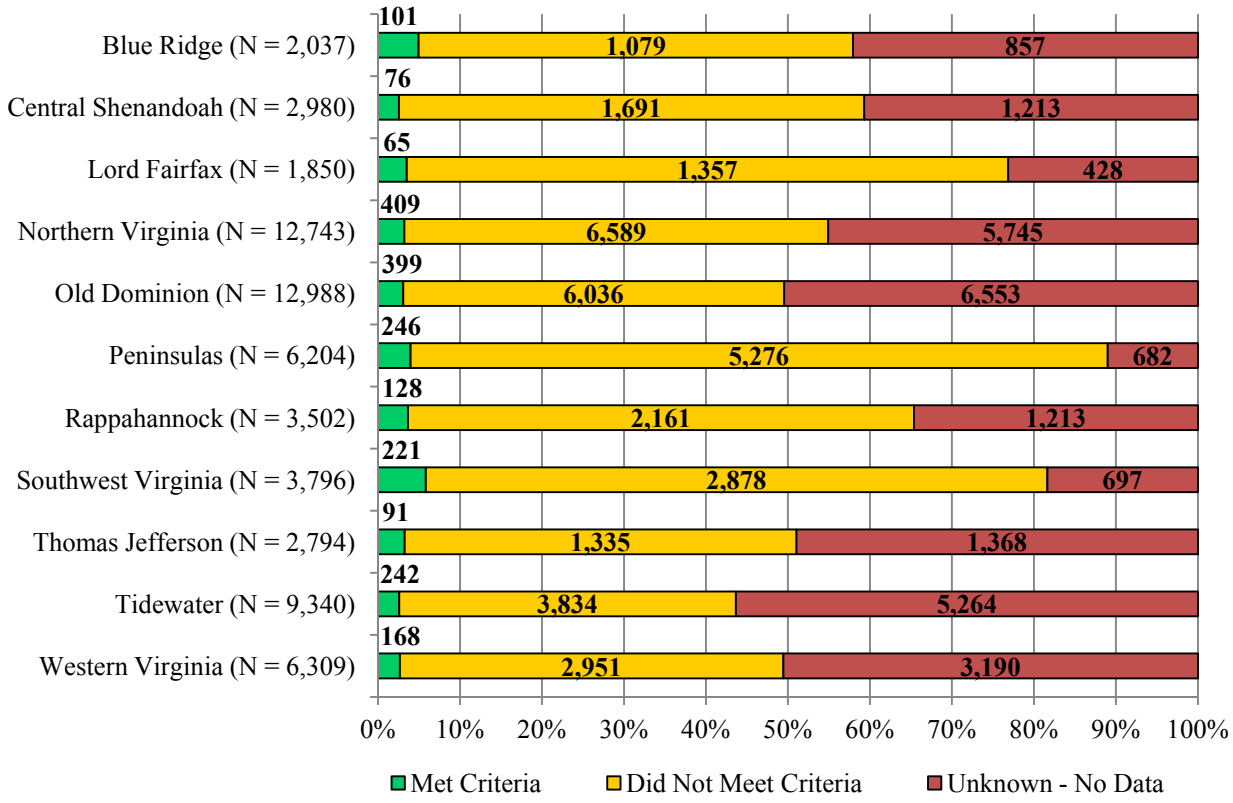


Figure 2. Virginia Step 1 Trauma Triage Criteria Status for Pre Hospital Patients by EMS Council Regions

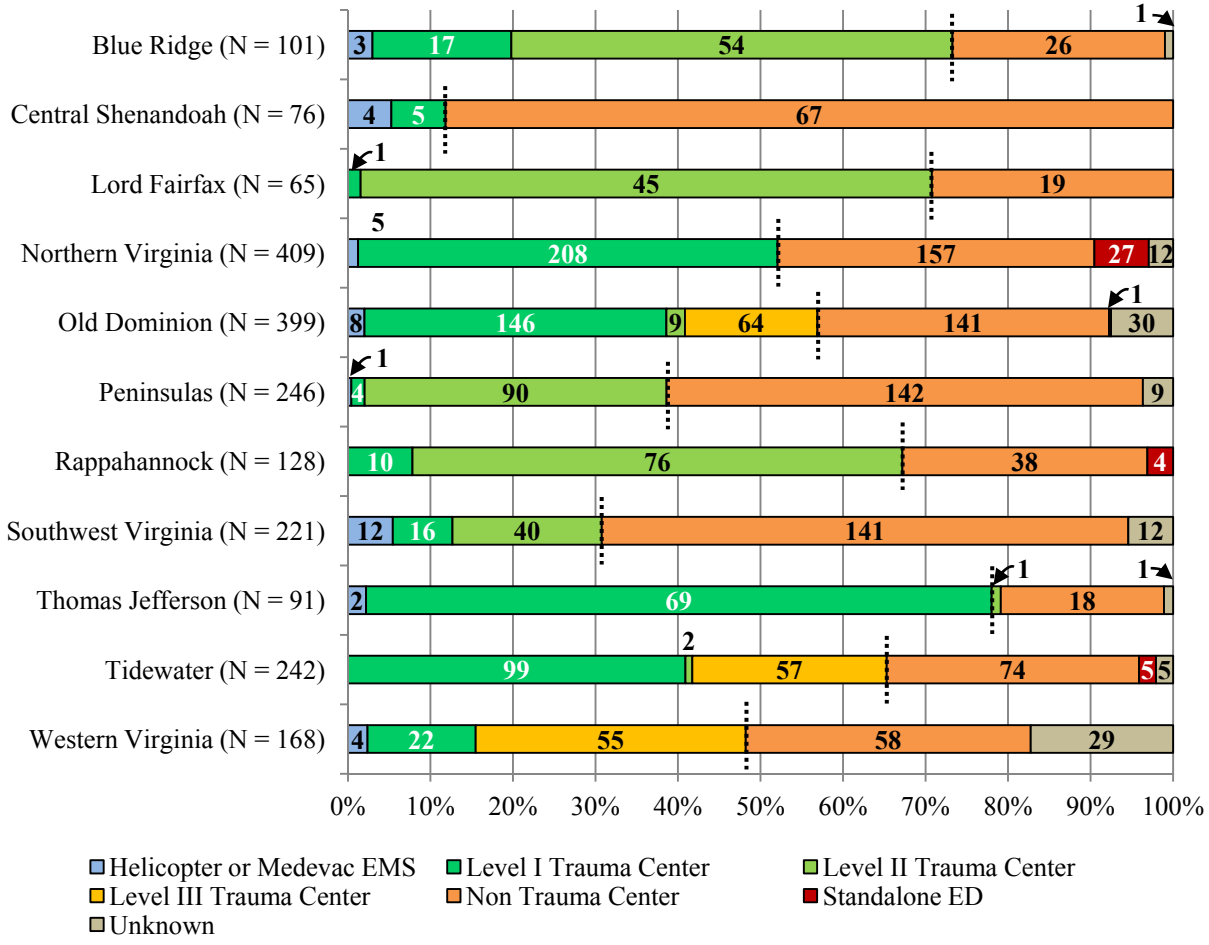
Includes All VPHIB Trauma Cases (N = 64,543)



The remaining 57.8 percent (37,333/64,543) "True 911" trauma cases had one or more of the vital sign values needed to determine if the patient met at least one of the Virginia Step 1 Field Trauma Triage Criteria. Only 5.7 percent (2,146/37,333) of these trauma patients met one or more of the Virginia Step 1 Field Trauma Triage Criteria. See Figure 3 for a breakdown of this information by Virginia EMS regions. The vertical dotted lines represent the boundary between correct (to the left) and incorrect (to the right) triage. The dotted line placement differs by EMS region because the access to trauma centers varies within the boundaries of each segment of the state. Appendix A shows a map of the 11 EMS regions and the locations of trauma centers in Virginia as well as in bordering states; non trauma center hospitals in Virginia are also included. Only two EMS regions, Northern Virginia and Thomas Jefferson, were thought to be capable of having all trauma patients who met one or more of the Virginia Step 1 Field Trauma Triage Criteria transported to a Level I trauma center. In Western Virginia, Old Dominion, and Tidewater only, Level III trauma centers were also considered acceptable destinations for this patient population. Geography (i.e., rivers in the eastern and mountains in the western parts of the state), as well as the actual locations of Virginia's Level I and Level II trauma centers, were factored into the decision to include Level III trauma centers as appropriate destinations. Level II trauma centers were used as the boundary for the remaining six EMS regions. Central

Shenandoah and Southwest Virginia have no trauma centers within their EMS regions but are reasonably close to a Level II trauma center in another EMS region or state. In addition, parts of Central Shenandoah are close to one of two Virginia Level I trauma centers. Lord Fairfax and Rappahannock have a Level II trauma center within their EMS regions as do Blue Ridge and Peninsulas. The latter two EMS regions, however, also have Level I trauma centers nearby.

Figure 3. Destinations of Pre Hospital Patients Meeting One or More Virginia Step 1 Trauma Triage Criteria by Virginia EMS Region *(N = 2,146)*



In recent years, the number of standalone emergency departments (EDs) has increased considerably. One potentially worrisome finding of this analysis was that 2.8 percent (1,833/64,543) of the trauma cases were transported to a standalone ED. Of these, 2.0 percent (37/1.833) met one or more, and 57.9 percent (1,061/1,833) did not meet any, of the Virginia Step 1 Field Trauma Triage Criteria. The remaining 40.1 percent (735/1,833) trauma cases transported to standalone EDs did not have any SBP, RR, or GCS values and therefore could not be classified as meeting (or not meeting) one or more of the Virginia Step 1 Field Trauma Triage Criteria. While the numbers are small, this is a trend that should be monitored in the future.

Numerous patient and other factors may influence the decision of to which facility a patient is transported. It was noted above that the availability of trauma center resources are not equally distributed across the state. Appendix B shows the accessibility of Adult Level I and Level II trauma centers within 45 minutes by helicopter or ambulance. In some areas (Southwest Virginia and Northern Virginia) out of state resources are available. In the Lord Fairfax EMS Region, residents of West Virginia and Maryland are included in the catchment area for Winchester Medical Center, one of Virginia's Level II trauma centers. Despite having a total of 9 Level I and Level II trauma centers (combined) and access to several other similar facilities in Tennessee and Washington, DC, large areas of the state are not covered. The situation appears even more grim when only ground ambulance transport is considered (Appendix C). Although a solution to this problem is beyond the scope of this report, the variability of resources, which is often compounded by geographic and – especially in the case of Helicopter or Medevac EMS – weather factors need to be considered when comparing the outcomes of pre hospital trauma patients in Virginia.

Incorrect Interfacility Transfer of Trauma Patients

Incorrect interfacility transfer of trauma patients is a much more difficult concept to operationalize. The *Virginia Department of Health Prehospital and Interhospital State Trauma Triage Plan* outlines several groups of factors to take into account with respect to the correctness of interfacility transfer of adult trauma patients (see Table 2). While some of these considerations can be translated into database queries, many cannot be evaluated because some of the crucial information is not available in the Virginia Statewide Trauma Registry (VSTR). With the exception of the Central Nervous System Triage Criterion of *GCS < 13* (discussed below), missing information was not an issue in this analysis.

Figure 4 provides graphical summaries of the interfacility transfer results outlined below. The dotted lines are used to differentiate between patients who met the specific criterion and were either admitted directly to a Level I or Level II trauma center (green) or who were later transferred to one of these facilities (gold) from those who did not receive care at a Level I or Level II trauma center (maroon and violet). *Incorrect interfacility transfer of trauma patients* is defined as the sum of the patients that were admitted elsewhere and were either transferred elsewhere or not transferred at all. Table 3 contains a summary of this information.

Respiratory Triage. The only criteria in this section that can be evaluated with the data available in the VSTR are *Significant unilateral injuries in patients under age 60* and *Flail chest*. The ICD-9-CM codes for these diagnoses (see the Appendix D) were used to create a flag variable which carries a value of "1" if the diagnosis code was present and "0" if it was not. Multiple occurrences of relevant ICD-9-CM diagnosis codes were counted only once. Only 83 records (0.3 percent) were excluded because of missing age data. Approximately one in 20 of VSTR cases met this criterion (1,694/31,472 = 5.4 percent). The vast majority of these patients (80.8 percent) were admitted directly to a Level I or Level II trauma center and 12.2 percent were admitted to other facilities and not transferred elsewhere. Of the 119 patients that were transferred, 95 (79.8 percent) were sent to a Level I or Level II trauma center; the remaining 24 (20.2 percent) patients went to other facilities.

Table 2. Adult Criteria

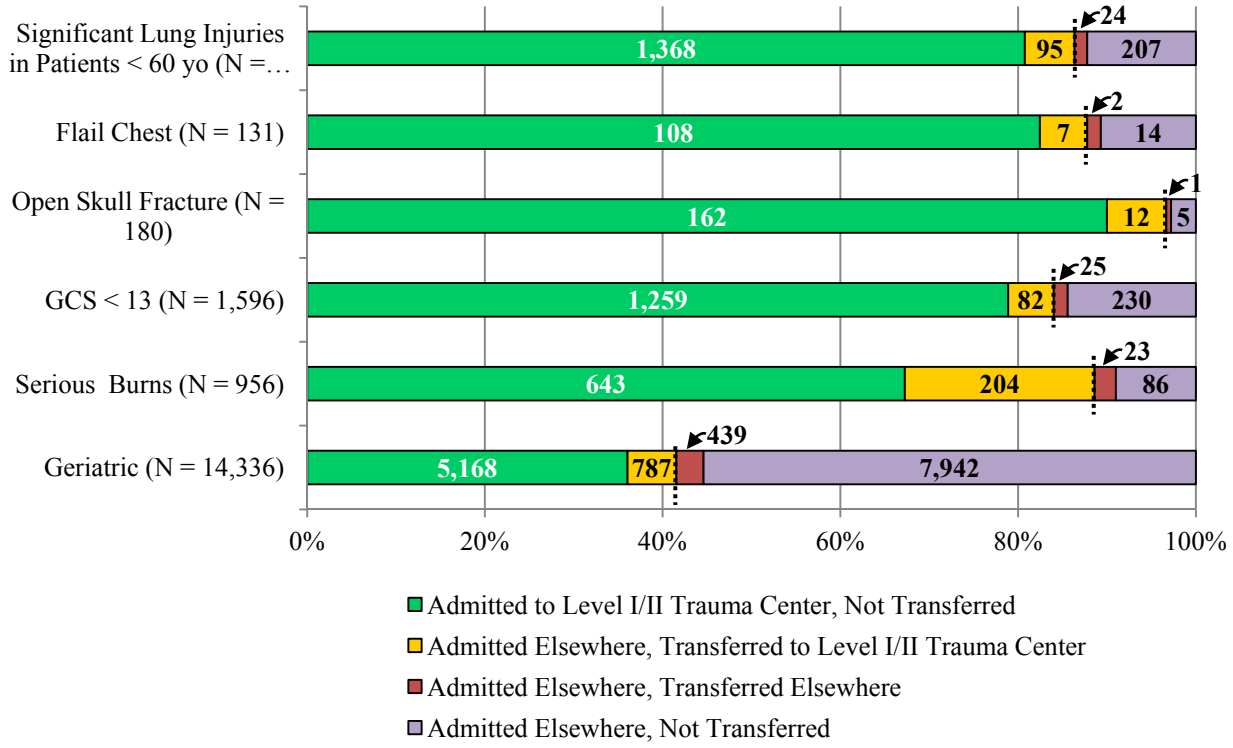
Based on the *Resources for Optimal Care of the Injured Patient: 1999* (American College of Surgeons, 1999) and adapted by the TSO&MC

Respiratory	**Cardiovascular**
Bilateral thoracic injuries	Hemodynamic instability as determined by the treating physician
Significant unilateral injuries in patients under age 60 (e.g. pneumothorax, hemo-pneumothorax, pulmonary contusion, >5 rib fractures)	Persistent hypotension
Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease	Systolic B/P (<100) without immediate availability of surgical team
Respiratory compromise requiring intubation	**Injuries**
Flail chest	Any penetrating injury to the head, neck, torso or extremities proximal to the elbow or knee without a surgical team immediately available.
Central Nervous System	Serious burns/burns with trauma
Unable to follow commands	Significant abdominal to thoracic injuries in patients where the physician in charge feels treatment of injuries would exceed capabilities of the medical center
Open skull fracture	**Special Considerations**
Extra-axial hemorrhage on CT, or any intracranial blood	Trauma in pregnancy (≥ 24 weeks gestation)
Paralysis	Special needs individuals
Focal neurological deficits	Geriatric
Glasgow Coma Scale (GCS) ≤ 12	Bariatric

Less than 1 percent of the cases represented patients with *Flail chest* (108/31,472 = 0.4 percent). The percentages of patients that were admitted directly to a Level I or Level II trauma center (82.4 percent) or were admitted to other facilities and not transferred elsewhere (10.7 percent) were similar to those described in the previous paragraph. Comparable distributions were also noted for patients transferred to a Level I or Level II trauma center (7/9 = 77.8 percent) or those transferred to other facilities (2/9 = 22.2 percent).

Central Nervous System Triage. It is not possible to evaluate the inability to follow commands, extra-axial hemorrhage on CT, or any intracranial blood, paralysis, and focal neurological deficits with the data available. However, the presence of an *Open skull fracture* should be discernible using ICD-9-CM diagnosis codes (see Appendix B) and cases with a *GCS < 13* should be identifiable from the patient's initial vital signs. During 2013, 90.0 percent (N = 165) of trauma patients with open skull fractures were admitted to a Level I or Level II trauma center. Of the remaining 18 patients that were admitted to other facilities, 12 (66.7 percent) were transferred to a Level I or Level II trauma center, 1 (5.6 percent) was transferred to elsewhere, and the remaining 5 patients (27.8 percent) were not transferred.

Figure 4. Admission and Transfer Status for Trauma Registry Cases *(N = 31,472)* Meeting Any of the Adult Triage Criteria for Interfacility Transfer



Unfortunately, 23.3 percent (7,324/31,472) of the VSTR records were missing the initial GCS value, so it was not possible to use *GCS < 13* as a means of determining whether or not these patients should be transferred. Approximately 1 in 15 (1,596/24,148 = 6.6 percent) of the remaining patients had an initial GCS value equal to or less than 12. The majority of these patients were admitted to a Level I or Level II trauma center (78.9 percent). Of the 337 patients admitted to other facilities, 68.2 percent were not transferred, 24.3 percent were transferred to a Level I or Level II trauma center, and the remaining 7.4 percent were transferred elsewhere.

Cardiovascular Triage. It was not possible to operationalize any of the Cardiovascular Criteria.

Injuries Triage. The only criterion from this group that can be evaluated with the available data is *Serious Burns*. The Appendix B contains a list of the ICD-9-CM diagnosis codes that were used to identify patients with severe thermal injury. Approximately 3 percent of the patients in the VSTR (956/31,742) had burns that were serious enough to warrant care at a burn center. The majority of these patients were admitted to a Level I or Level II trauma center (643/956 = 67.3 percent). Of the 313 patients admitted elsewhere, 21.3 percent were transferred to a Level I or Level II trauma center, 2.4 percent were transferred to other facilities, and the remaining 9.0 percent were not transferred.

Table 3. Percentage Values for the Four Possible Patient Scenarios

	Patients Initially Taken to a Level I or Level II Trauma Center (Ideal)	Patients Initially Taken Elsewhere, But Were:			
		Trans-ferred to a Level I or Level II Trauma Center (Correct)	Trans-ferred Elsewhere (Incorrect)	Not Trans-ferred (Incorrect)	Overall Incorrect
Significant Lung Injuries in Patients < 60 yo	80.8	5.6	12.2	1.4	13.6
Flail Chest	82.4	5.3	10.7	1.5	12.2
Open Skull Fracture	90.0	6.7	2.8	0.6	3.3
GCS < 13	78.9	5.1	14.4	1.6	16.0
Serious Burns *	59.7	22.5	14.9 **	2.9	17.8
Geriatric	36.0	5.5	55.4	3.1	58.5

* Values for *Serious Burns* use ***burn centers*** rather than *Level I or Level II trauma centers*

** Approximately half of the serious burn patients that were transferred elsewhere were transferred to a Level I or Level II trauma center

Somewhat similar results were noted when a destination of a burn center was used in place of a Level I or Level II trauma center. Most of the patients with serious burns were taken directly to a burn center (571/956 = 59.7 percent). Of the remaining 385 patients that were taken to other facilities, 215 (55.8 percent) were transferred to a burn center, 28 (7.3 percent) were transferred elsewhere, and 142 (36.9 percent) remained at the facility to which they were originally admitted. Approximately half (72/142 = 50.7 percent) of these patients had been admitted to a Non burn center Level I or Level II trauma center.

Special Considerations Triage. The only criterion in this category that could be assessed was *Geriatric*. An age of 65 years or older was used to define this group. All but 83 of records had a patient age (31,389/31,472 = 99.7 percent); only those cases with an age were included in the analysis. Geriatric patients represented the largest group of triage criteria met; almost one in two (14,336/31,472 = 45.6 percent) of all trauma patients were 65 years of age or older. However, unlike the other triage criteria noted above, only about one-third (5,168/14,336 = 36.0 percent) were admitted to a Level I or Level II trauma center. Of the 9,168 geriatric patients admitted to other facilities, 7,942 (86.6 percent) were not transferred elsewhere. Of those patients that were transferred, almost twice as many were transferred to a Level I or Level

II trauma center (787/9,168 = 8.6 percent) as were transferred elsewhere (439/9,168 = 4.8 percent).

Observations. According to the sources cited in the *Virginia Department of Health Prehospital and Interhospital State Trauma Triage Plan,* patients who are transferred to a Level I or Level II trauma center when indicated tend to have better outcomes both in terms of morbidity and mortality. Despite the results reported in Figure 3 and Table 3, Virginia compares well with other states for overall injury deaths per 100,000 (see Appendix E). Virginia shares the lowest death rate quintile with California, Connecticut, Hawaii, Illinois, Massachusetts, Minnesota, New Hampshire, New Jersey, and New York. While the overall injury death rate per 100,000 for Virginia is 52.59, the values of individual counties and cities across the state range from a low of 25.04 to a high of 141.14. Appendix F contains a map of Virginia by city/county using the same color scheme as in Appendix E. While Virginia compares well to other states overall, there is a nearly six-fold variation in injury death rates per 100,000 among the cities and counties. Loudoun County has both the minimum injury death rate for the state and the nation, while Dickenson County has the maximum value for the state and is in the 99th percentile for the country. Only 33 counties of the 2,941 with reportable data nationwide had higher injury death rates than Dickenson County. The wide range of values for injury deaths per 100,000 made us wonder if something similar was happening with overall deaths per 100,000. Appendix G shows this information using the same color scheme as Appendix F. The similarities in several areas of the state were striking. An informal comparison of the percentage of deaths due to injury by city/county population revealed some trends toward higher population areas having lower percentages of death due to injury. A detailed analysis of this phenomenon is beyond the scope of this report but would be interesting to explore in future reports.

Conclusions

Incorrect Trauma Triage by Emergency Medical Services Agencies. The large amount of missing vital signs data is an obvious place to begin improvement efforts. It may be reasonable to not record vital signs information in some situations. For example, no patient may be found by the ambulance crew, the patient may be dead on scene, or the patient may refuse evaluation and/or care. However, all of the patient cases included in this analysis were "True 911" calls in which the patient was treated and transported to a hospital. It is difficult to imagine a scenario in which two out of every five patients (42.2 percent) had no recorded SBP, RR, or GCS. Since this report is based on 2013 data and is being submitted as 2014 comes to a close, it would make sense to rerun the analysis once the 2014 data are complete (February 2015) to determine if the lack of submission of vital signs data has changed. The 2014 results can be used to provide reports to individual agencies as well as to their EMS regions.

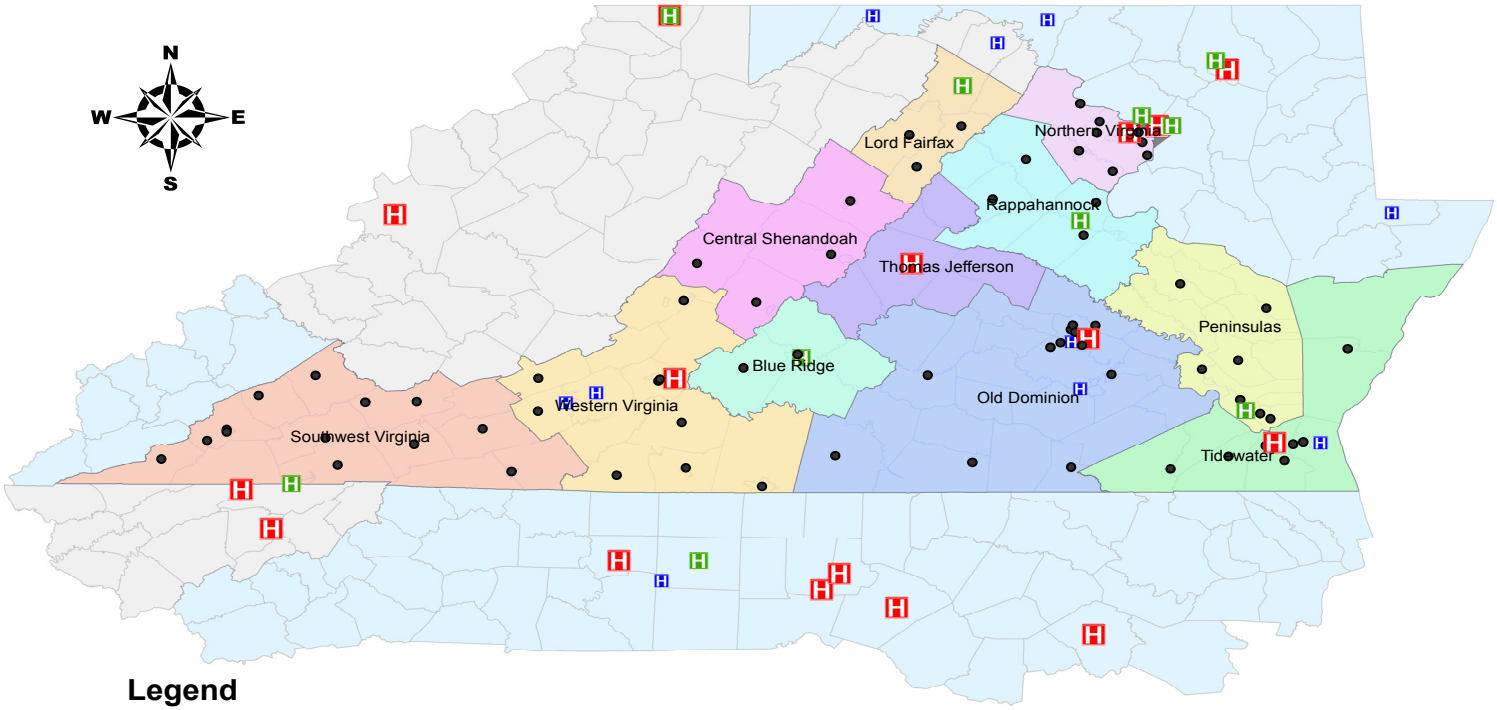
It is hoped that the give and take of providing specific agency level data to the providers, along with encouraging constructive feedback, will help to determine some of the other less obvious explanatory issues. This information should allow for the development of a performance improvement plan for the triage of pre hospital trauma patients.

Incorrect Interfacility Transfer of Trauma Patients. Based on the few interfacility triage criteria that could be evaluated, the rates of incorrect interfacility transfers of trauma

patients had a minimum of 3.3 percent *(Open Skull Fracture)* maximum of 58.5 percent *(Geriatric)*. The remaining four values ranged between 12.2 percent and 17.8 percent. While there is room for improvement overall, special attention will be focused on learning more about the reasons for the incorrect interfacility transfers for trauma patients meeting the *Geriatric* and *Serious Burns* criteria.

As was the case with the VPHIB data, missing vital signs – predominantly GCS values – were also a problem in the VSTR. The prevention of missing data will be another area of focus for improvement in the coming year. New VSTR software was put into place as of January 1, 2014. Past experience has taught that the initial year of implementing a large statewide database can result in some data quality issues. However, the enhanced dataset being collected and the ability to provide complex evaluations of the validity of data as they are submitted should mitigate this problem. It is hoped that the feedback provided on an ongoing basis will result in more complete and better quality data for the VSTR.

Appendix A. Location of Trauma Centers and Hospitals in Virginia and Nearby Trauma Centers in Surrounding States



Legend

Hospitals

- Non Trauma Centers

Trauma Center Designation

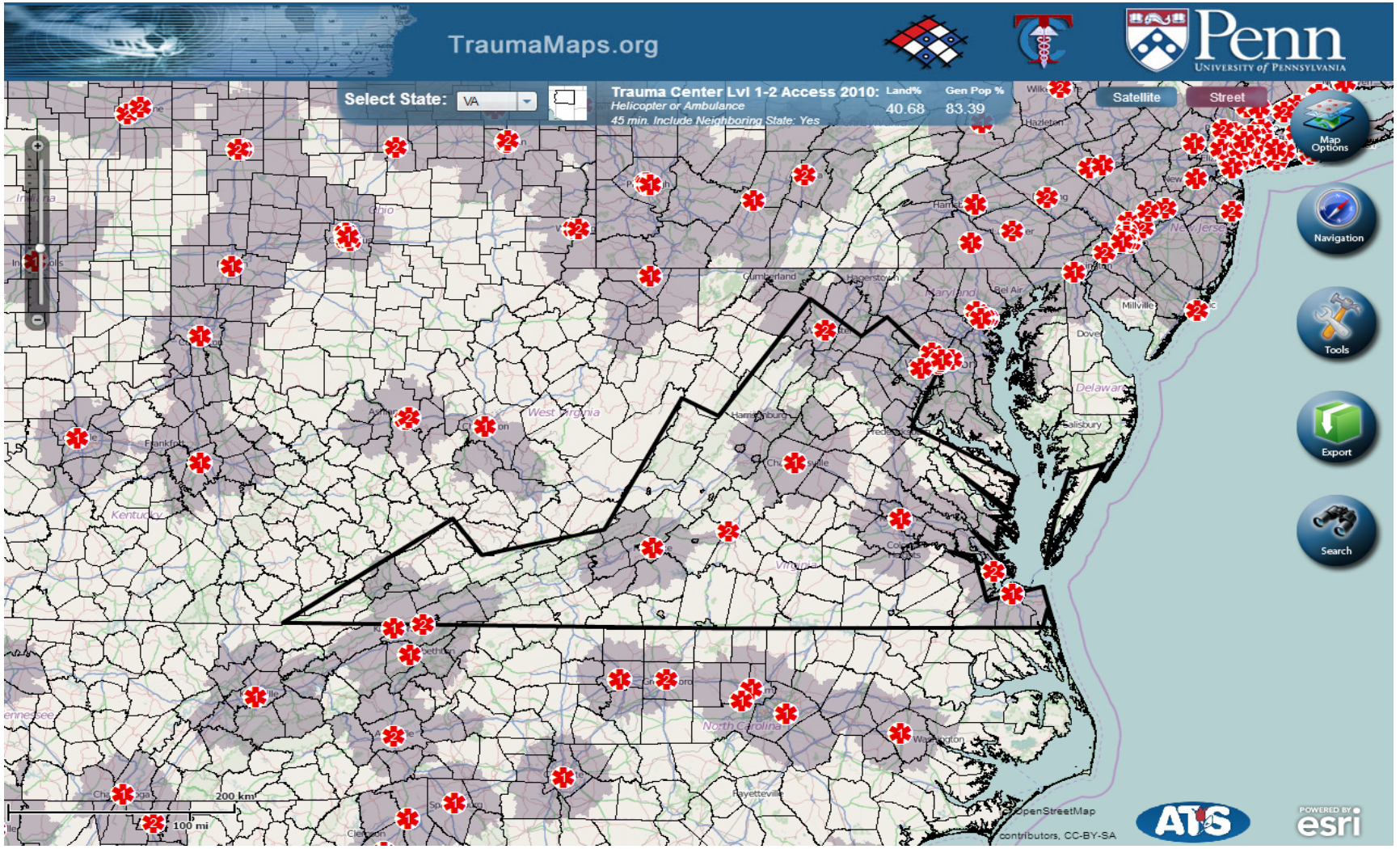
- Level I
- Level II
- Level III

EMS Regions

Names of Regions

- Blue Ridge
- Central Shenandoah
- Lord Fairfax
- Northern Virginia
- Old Dominion
- Peninsulas
- Rappahannock
- Southwest Virginia
- Thomas Jefferson
- Tidewater
- Western Virginia

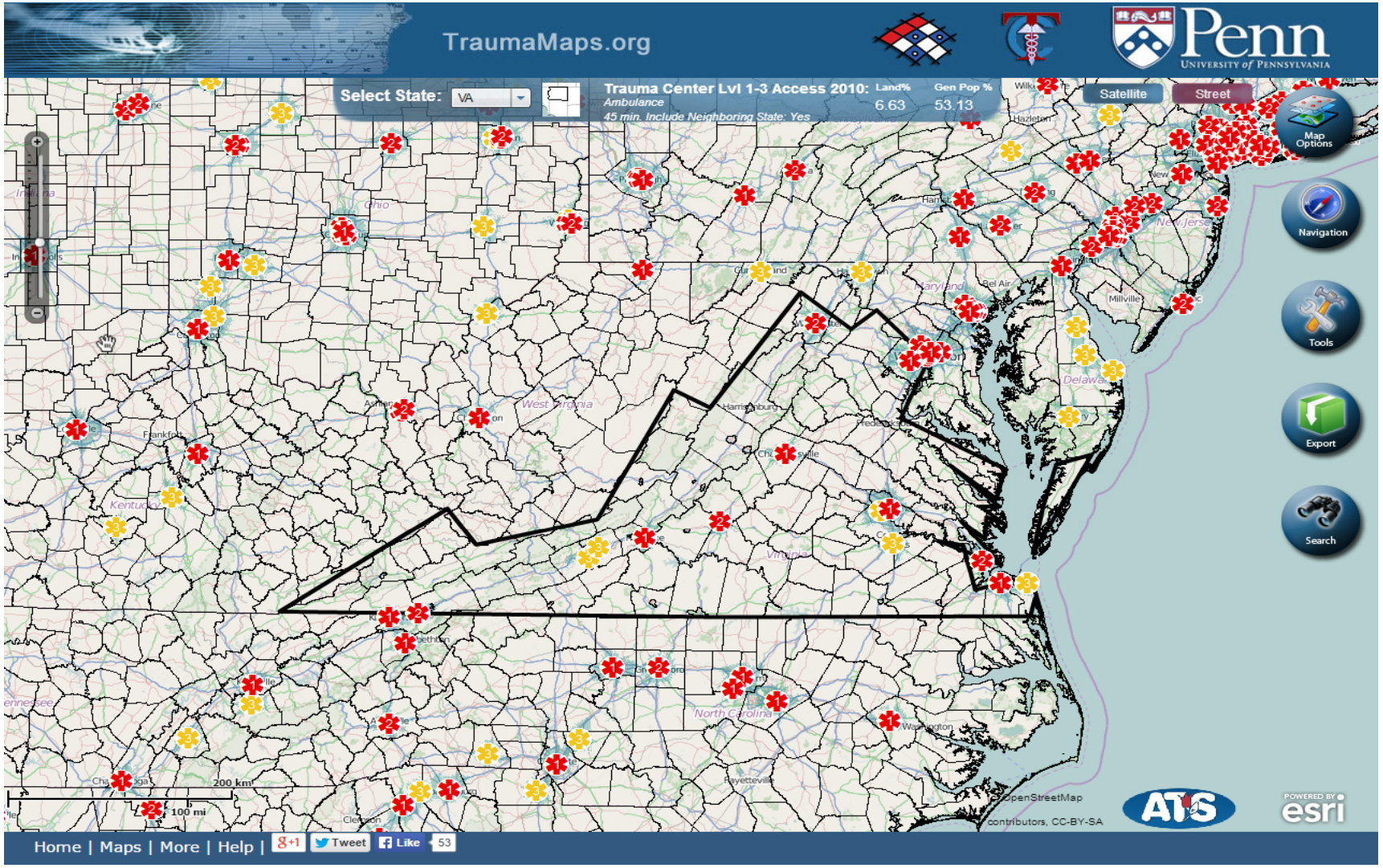
Appendix B. Adult Level I and II Trauma Centers within 45 Minutes Access Time via Helicopter or Ambulance for Virginia and Neighboring States



Source: www.traumamaps.org, accessed 12/04/2014

Note: Mary Washington Hospital (Level 2, Fredericksburg) is missing

Appendix C. Adult Level I - III Trauma Centers within 45 Minutes Access Time via Ambulance Only for Virginia and Neighboring States



Source: www.traumamaps.org, accessed 12/04/2014

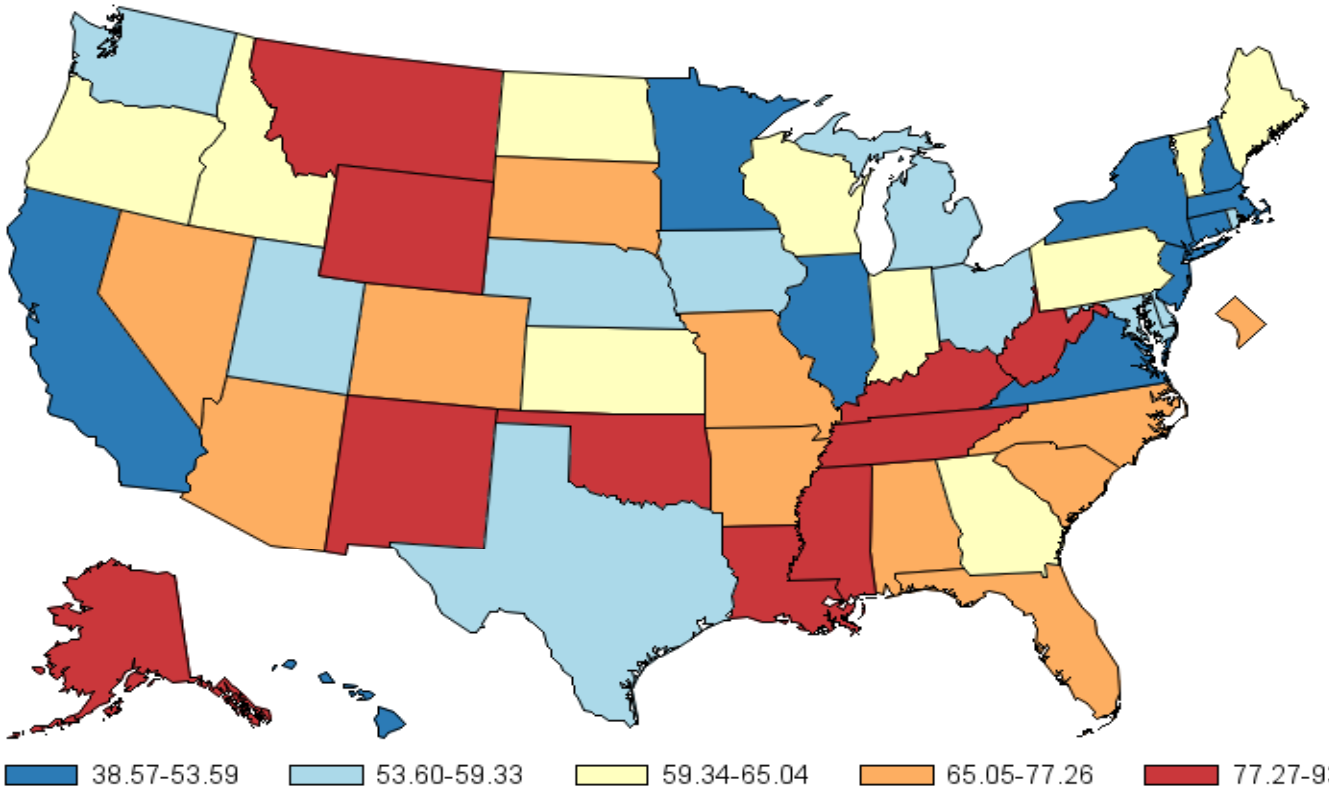
Note: Mary Washington Hospital (Level 2, Fredericksburg) is missing

APPENDIX D:
ICD-9-CM Diagnosis Codes Used for Incorrect Interfacility Transfer of Trauma Patients

Respiratory Criteria				
807.06	807.09	807.18	860	860.5
807.07	807.16	807.19	860.1	861.21
807.08	807.17	807.4	860.4	861.31
Skull Fracture Criteria				
800.5	800.9	801.8	803.7	804.6
800.51	800.91	801.81	803.71	804.61
800.52	800.92	801.82	803.72	804.62
800.53	800.93	801.83	803.73	804.63
800.54	800.94	801.84	803.74	804.64
800.55	800.95	801.85	803.75	804.65
800.56	800.96	801.86	803.76	804.66
800.59	800.99	801.89	803.79	804.69
800.6	801.5	801.9	803.8	804.7
800.61	801.51	801.91	803.81	804.71
800.62	801.52	801.92	803.82	804.72
800.63	801.53	801.93	803.83	804.73
800.64	801.54	801.94	803.84	804.74
800.65	801.55	801.95	803.85	804.75
800.66	801.56	801.96	803.86	804.76
800.69	801.59	801.99	803.89	804.79
800.7	801.6	803.5	803.9	804.8
800.71	801.61	803.51	803.91	804.81
800.72	801.62	803.52	803.92	804.82
800.73	801.63	803.53	803.93	804.83
800.74	801.64	803.54	803.94	804.84
800.75	801.65	803.55	803.95	804.85
800.76	801.66	803.56	803.96	804.86
800.79	801.69	803.59	803.99	804.89
800.8	801.7	803.6	804.5	804.9
800.81	801.71	803.61	804.51	804.91
800.82	801.72	803.62	804.52	804.92
800.83	801.73	803.63	804.53	804.93
800.84	801.74	803.64	804.54	804.94
800.85	801.75	803.65	804.55	804.95
800.86	801.76	803.66	804.56	804.96
800.89	801.79	803.69	804.59	804.99

Severe Burns Criteria							
940	941.29	942.25	943.35	944.18	944.58	946.5	948.71
940.1	941.3	942.29	943.36	944.2	945.2	947	948.72
940.2	941.31	942.3	943.39	944.21	945.21	947.1	948.73
940.3	941.32	942.31	943.4	944.22	945.22	947.2	948.74
940.4	941.33	942.32	943.41	944.23	945.23	947.3	948.75
940.5	941.34	942.33	943.42	944.24	945.24	947.4	948.76
940.9	941.35	942.34	943.43	944.25	945.25	947.8	948.77
941	941.36	942.35	943.44	944.26	945.26	947.9	948.8
941.01	941.37	942.39	943.45	944.27	945.29	948	948.81
941.02	941.38	942.4	943.46	944.28	945.3	948.11	948.82
941.03	941.39	942.41	943.49	944.3	945.31	948.2	948.83
941.04	941.4	942.42	943.5	944.31	945.32	948.21	948.84
941.05	941.41	942.43	943.51	944.32	945.33	948.22	948.85
941.06	941.42	942.44	943.52	944.33	945.34	948.3	948.86
941.07	941.43	942.45	943.53	944.34	945.35	948.31	948.87
941.08	941.44	942.49	943.54	944.35	945.36	948.32	948.88
941.09	941.45	942.5	943.55	944.36	945.39	948.33	948.9
941.1	941.46	942.51	943.56	944.37	945.4	948.4	948.91
941.11	941.47	942.52	943.59	944.38	945.41	948.41	948.92
941.12	941.48	942.53	944	944.4	945.42	948.42	948.93
941.13	941.49	942.54	944.01	944.41	945.43	948.43	948.94
941.14	941.5	942.55	944.02	944.42	945.44	948.44	948.95
941.15	941.51	942.59	944.03	944.43	945.45	948.5	948.96
941.16	941.52	943.2	944.04	944.44	945.46	948.51	948.97
941.17	941.53	943.21	944.05	944.45	945.49	948.52	948.98
941.18	941.54	943.22	944.06	944.46	945.5	948.53	948.99
941.19	941.55	943.23	944.07	944.47	945.51	948.54	949.2
941.2	941.56	943.24	944.08	944.48	945.52	948.55	949.3
941.21	941.57	943.25	944.1	944.5	945.53	948.6	949.4
941.22	941.58	943.26	944.11	944.51	945.54	948.61	949.5
941.23	941.59	943.29	944.12	944.52	945.55	948.62	
941.24	942.2	943.3	944.13	944.53	945.56	948.63	
941.25	942.21	943.31	944.14	944.54	945.59	948.64	
941.26	942.22	943.32	944.15	944.55	946.2	948.65	
941.27	942.23	943.33	944.16	944.56	946.3	948.66	
941.28	942.24	943.34	944.17	944.57	946.4	948.7	

Appendix E. 2004-2010, United States
Death Rates per 100,000 Population
All Injury, All Intents, All Races, All Ethnicities, Both Sexes, All Ages
Annualized Crude Rate for United States: 58.92

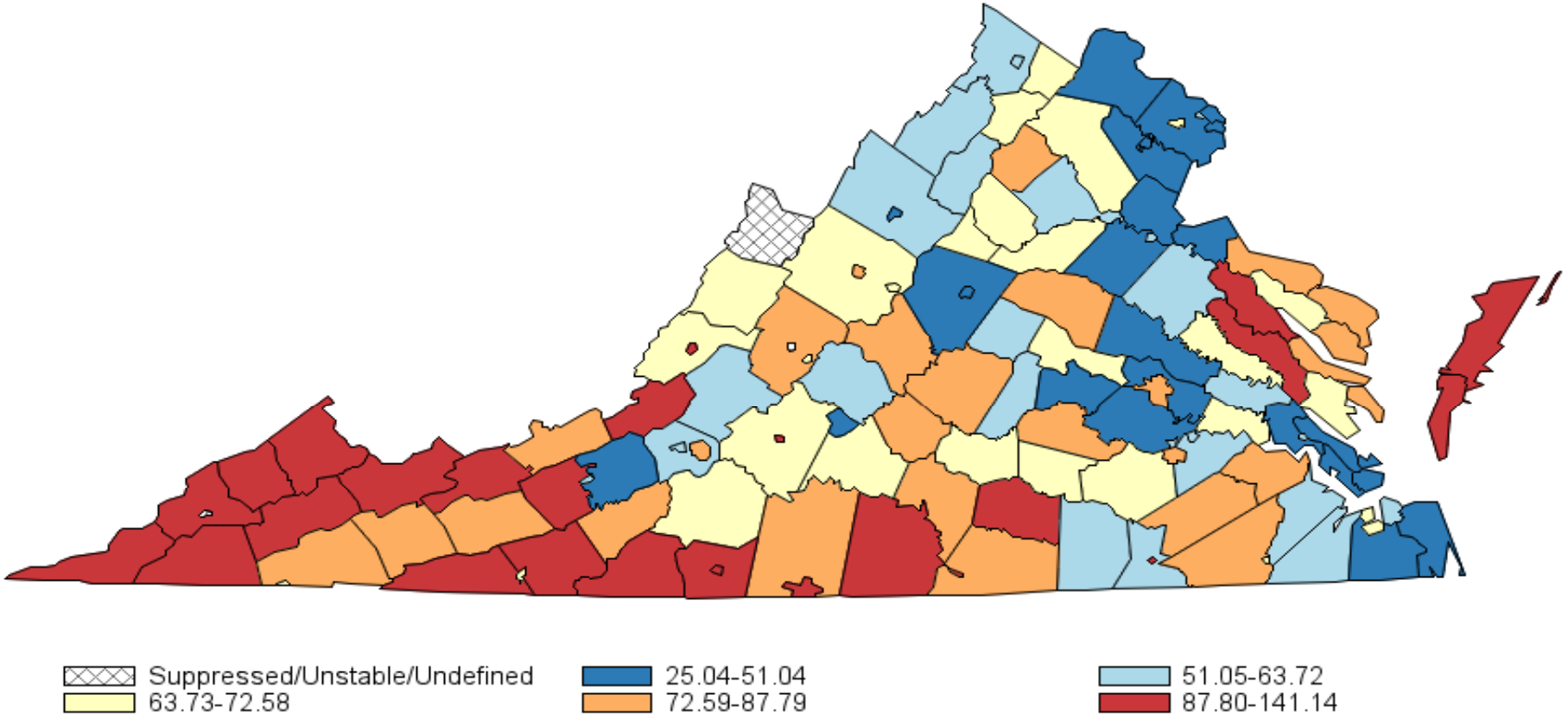


Reports for All Ages include those of unknown age.
* Rates based on 20 or fewer deaths may be unstable. States with these rates are cross-hatched in the map (see legend above). Such rates have an asterisk

Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

Source: http://wisqars.cdc.gov:8080/cdcMapFramework/mapModuleInterface.jsp, accessed 12/04/2014

Appendix F. 2004-2010, Virginia
Death Rates per 100,000 Population
All Injury, All Intents, All Races, All Ethnicities, Both Sexes, All Ages
Annualized Crude Rate for Virginia: 52.59

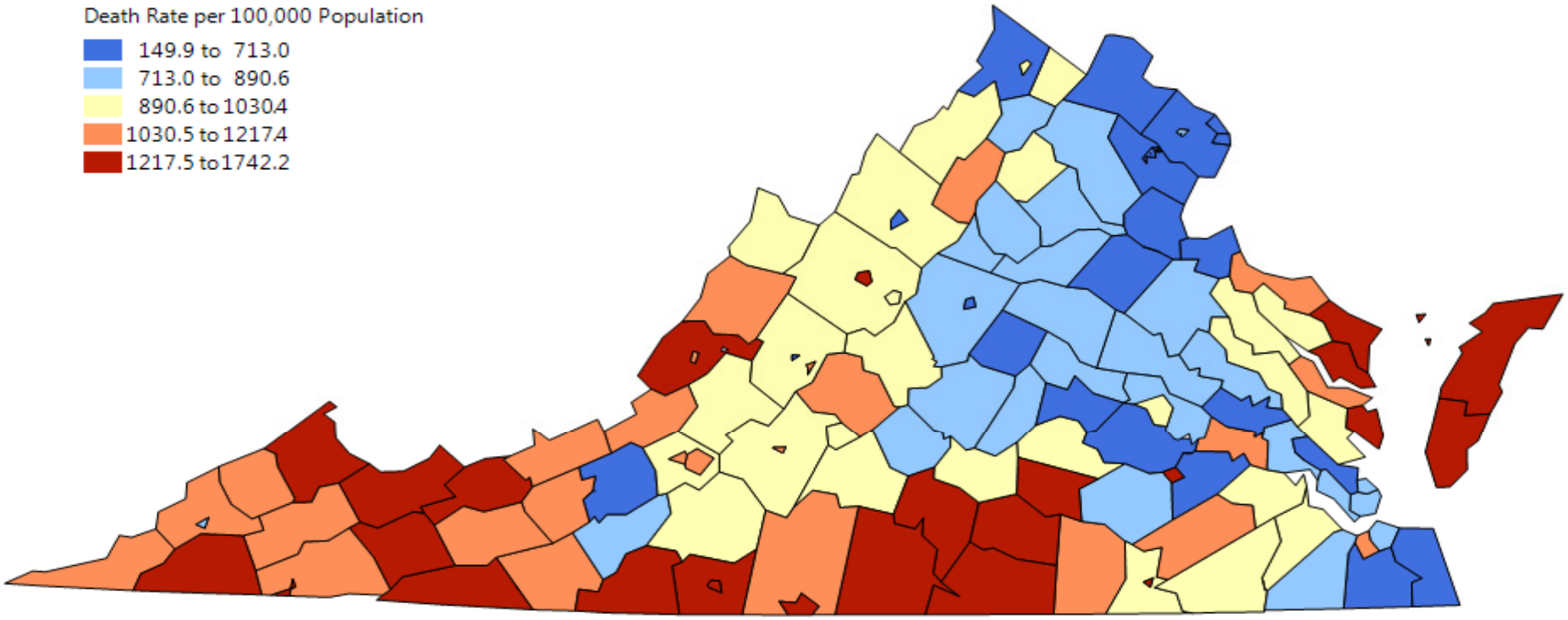


Reports for All Ages include those of unknown age.
* Rates based on 20 or fewer deaths may be unstable. These rates are suppressed for counties (see legend above); such rates in the title have an asterisk.

Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

Source: http://wisqars.cdc.gov:8080/cdcMapFramework/mapModuleInterface.jsp, accessed 12/04/2014

Appendix G. Virginia Comprehensive Death Rates per 100,000 Population for 2013



Data Source: http://www.census.gov/popest/data/counties/totals/2013/files/CO-EST2013-Alldata.csv, accessed 12/04/2014